HealthWorks for Northern Virginia
Your Community Health Center
Quality Healthcare for All

Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I have been made aware of HealthWorks for Northern Virginia (HW) Notice of Privacy Practices and that I have the right to receive a copy upon request. This Notice describes the type of uses and disclosures of my protected health information that might occur during my treatment to facilitate claim payments or to monitor the performance of HW's health care operations. The Notice also describes my rights and HW's duties with respect to my protected health information. I understand that copies of the Notice of Privacy Practices are available in the registration areas of each facility and on the HW website at: www.hwnova.org.

Patient Name:
Patient Date of Birth:
Legal Representative Name (Print):
Patient or Legal Representative (Signature):
Date:

✓ I authorize release of Personal Health Information to the following family members or friends who are involved in my care:

1. Name:	2. Name:
Relationship to Patient:	Relationship to Patient:
Phone Number: ( )	Phone Number: ( )

✓ I authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome), HIV (Human Immunodeficiency Virus) or Sickle Cell Anemia. □ **Yes** □ **No**

Patient or Legal Representative (Signature):
Date: