capitalhealth
CENTER FOR
COMPREHENSIVE BREAST CARE

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NOTICE OF PRIVACY PRACTICES
CAPITAL HEALTH SYSTEM

I, _____ acknowledge that I

have received a copy of Capital Health System's Joint Notice of Privacy Practices.

Signature:_____

Today's Date:_____

Living Will:

Do you have a Living Will and Durable Power of Attorney? YES NO

- If YES, please furnish us with a copy for your medical chart or allow us to make a copy to attach to your chart. Thank you.
- If NO, would you like more information regarding this subject? YES NO

Contact Information:

When we need to contact you about test results, prescription refills, referrals, etc, can we leave a message on your:

Home number:_____

Cell number:_____

Capital Health and the Center for Comprehensive Breast Care has permission to speak to the following on my behalf:_____

Signature:_____

Printed name:_____

Date of Birth:_____

Today's Date:_____