Penn Medicine
Chester County Hospital

The Women's Specialty Center

Susan Chang, MD
Catherine Porter, DO
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**Acknowledgement: Receipt of the Women's Specialty Center's Notice of Privacy Practices**

I acknowledge that I received the Notice of Privacy Practices from Women's Specialty Center.

__________________________________________________________
Name of patient

**Restricted Communication Request**

I hereby request that test results may only be left on the following phone number and voice mail system(s).

____________________________________________________

**Designation of Personal Representative (Select & Sign)**

☐ I choose not to designate any other person as my personal representative

☐ In addition to myself, I designate the following individual(s) as my personal representative and grant Women's Specialty Center permission to disclose (written and verbal) my Protected Health information with the individual(s) named below.

| Name of representative | Relationship to patient |
|---|---|
| | |
| Name of representative | Relationship to patient |
| Name of representative | Relationship to patient |

__________________________________________________________
**REQUIRED SIGNATURE** Date of receipt

I understand that I may revoke this authorization at any time.