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## **Acknowledgment and Receipt of Notice of Privacy Practices**

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this acknowledgement. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by submitting a request.

By signing this form, you acknowledge receipt of our notice regarding use and disclosure of protected health information about you for treatment, payment and healthcare operations as described in the notice.

Your health information cannot and will not be shared with any parties without your written consent; however, if your current insurance company needs to evaluate medical records in order to pay for a claim, we will submit it to them immediately upon their request.

Please list the names of individuals that we may release information to if they were to call on your behalf. List their full names and their relationship to you. Your information can only go to those listed below.

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Patient Name: \_\_\_\_\_

Patient/Representative Signature: \_\_\_\_\_

Date: \_\_\_\_\_