



# ACKNOWLEDGEMENT OF RECEIPT OF HIPAA/NOTICE OF PRIVACY PRACTICES

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| <p><b>To be completed by WMY Health Center Staff</b></p> <p><b>Patient Name</b> _____</p> <p><b>Date of Birth</b> _____</p> <p><b>Medical Record #</b> _____</p> |
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I, \_\_\_\_\_ acknowledge that I have received  
(Please print name of patient)  
a copy of Whitney M. Young, Jr. Health Center’s (WYH) Health Insurance Privacy and Accountability Act (HIPAA) Notice of Privacy Practices. This notice describes how WYH may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and privacy rights I have regarding my protected health information.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Legal Representative (Please print)

\_\_\_\_\_  
Date