ACKNOWLEDGEMENT OF RECEIPT OF HIPAA/NOTICE OF PRIVACY PRATICES

To be completed by WMY Health Center Staff

Patient Name _____

Date of Birth _____

Medical Record # _____

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