WMC Health | Westchester Medical Center

Westchester Medical Center Health Network

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

By signing below, I acknowledge that I have been provided a copy of the Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the hospital and the facilities listed at the beginning of this notice, and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV-related information, alcohol and substance abuse treatment information, mental health information and genetic information.

Signature of Patient or Personal Representative

Print Name of Patient or Personal Representative

Date/Time

Description of Personal Representative's Authority

OFFICE USE ONLY:

☐ Patient is unable to sign due to condition

☐ Patient refused to sign

Hospital Staff Person's Name

Date & Time