WESTCHESTER MEDICAL REGIONAL PHYSICIAN SERVICES, P.C.

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 WMRPS and how I may obtain access to and control this information. I 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 Print Name of Patient

_____ _____

Signature of Representative Print Name of Representative

_____ _____

Date Description of Representative Authority

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Signature Acknowledgement Not Obtained

Please document your efforts to obtain acknowledgment and reason it was not obtained.

- Notice of Privacy Practice Given …….Patient Unable to Sign
- Notice of Privacy Practice Given……. Patient Declined to Sign
- Notice of Privacy Practice Mailed to Patient….Awaiting Signature
- Other Reason Patient Did Not Sign

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Signature of WMRPS Representative Date