West Side Physical Therapy, PC

Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I have received a copy of Notice of Privacy Practices from West Side Physical Therapy, PC. This Notice describes the types of uses and disclosures of my protected health information that may occur in my treatment, payment of my bills or in the performance of West Side Physical Therapy, PC's healthcare operations. The Notice of Privacy Practices also describes my rights and West Side Physical Therapy, PC's duties with respect to my protected health information.
West Side Physical Therapy, PC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by the calling the office and requesting a revised copy.

Signature of Patient or Personal Representative

_____

Printed Name of Patient or Representative

_____

Date

_____

Description of Personal Representative's Authority
(Example: Parent/Legal Guardian, Power of Attorney)

******PLEASE ALLOW THE STAFF OF WSPT TO DISCUSS MY PROTECTED HEALTH INFORMATION WITH THE FOLLOWING INDIVIDUALS. *(I CAN REMOVE ANY OF THESE INDIVIDUALS FROM THIS LIST IN THE FUTURE WITH A WRITTEN COMMUNICATION.) ~~**YOU DO NOT NEED TO LIST YOUR REFERRING PHYSICIAN IN THIS SECTION~~~***

1. _____ 2. _____

3._____ 4. _____

5. _____ 6. _____