

PATIENT ACKNOWLEDGEMENT
John E. West, M.D., P.C.
Privacy Practices

Patient's Name: _____ DOB: _____ Acct: _____

SSN: _____ Previous Name: _____

I understand that the patient's health information is private and confidential. I understand that John E. West, M.D., P.C. may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual.

John E. West, M.D., P.C. has a detailed document called the "Notice of Privacy Practices". Within this "Notice of Privacy Practices" is contained a complete description of my privacy/confidentiality rights. These rights include, but aren't limited to, access to my medical records, restrictions on certain uses, receiving an accounting of disclosures as required by law, and requesting communication by specified methods of communication.

John E. West, M.D., P.C. has established procedures which help them meet their obligations to patients. These procedures may include other signature requirements, written acknowledgments, and authorizations; reasonable time frames for requesting information; charges for copies and non-routine information needs; etc. I will assist John E. West, M.D., P.C. by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices".

My signature below acknowledges that I am aware of and have been given the opportunity to review the "Notice of Privacy Practices" for John E. West, M.D., P.C.

Patient Signature Date

Guardian Signature Date