

HIPAA PRIVACY PRACTICES ACKNOWLEDGMENT FORM



Our Privacy Practices Explanation provides information about how we may use and disclose protected health information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy.

Please fill out this form to indicate your acceptance of the terms.

I, _____
Printed patient name

have received a printed copy of Watershed Wellness' Privacy Practices Explanation. I have been given an opportunity to read this explanation. I understand that I may ask Watershed Wellness any questions if I do not understand any information contained in the privacy practices explanation.

Patient Signature

Date of Signature

Alternative: Signature of authorized representative of patient

Relationship to Patient