HIPAA Privacy Acknowledgment Form

Whitebridge Pulmonary Care

Patient Name: _____

Date of Birth: _____

I acknowledge that I have received and had the opportunity to review the Notice of Privacy Practices from Whitebridge Pulmonary Care. This Notice describes how my health information may be used or disclosed and outlines my rights regarding this information.

I understand that:

- My personal health information is protected by law.
- I have the right to request restrictions on how my information is used or shared.
- I can revoke this acknowledgment in writing at any time.

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if applicable): _____ Date: _____

Staff Signature: _____ Date: _____

If the patient is unable to sign, please indicate the reason:

_____

Whitebridge Pulmonary Care thanks you for taking the time to review our privacy practices.