



HIPAA Acknowledgement of Receipt

I, _____, hereby acknowledge that I have been given a copy of the Notice of Privacy practice under the HIPAA from West Michigan Ketamine Clinics. I further acknowledge that I have had the opportunity to ask questions and receive answers to my satisfaction about this privacy policy.

I give West Michigan Ketamine Clinics permission to contact me on the phone number(s) provided on my medical chart. I give West Michigan Ketamine Clinics permission to leave any messages with detailed information on the voicemail or messaging service

WMKC to release any medical information to the following:

Name:
Relation:
Phone:

Name:
Relation:
Phone:

****New privacy information:** The Health Information Exchange is a “limited view” of your electronic patient chart that may be accessed by different health care facilities for continuing care. If you would not like this information shared, you may “opt-out”, which means you may request to not have your records be shared. Please ask the front desk staff for an instruction sheet and to explain the “opt-out” process.

My below signature indicates that I have read and understand and agree to the policies and procedures of this office, and for any and all medical health information to be shared with the named personnel's above.

Printed Patient Name

Patient Signature -or-
Parent/Legal Guardian

Date