



## *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