WESTWIND MEDICAL ASSOCIATES
HEALTH & WELLNESS CENTER

HIPPA Acknowledgement Form

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Acknowledgement of Receipt
WESTWIND MEDICAL ASSOCIATES, P.A.
Notice of Privacy Practices

Your signature below acknowledges that you have received a copy of the Privacy Practices Notice from the office of WESTWIND MEDICAL ASSOCIATES, P.A.

Patient/Parent Signature _____ D.O.B. [ ] Date: [ ]

Guarantor Signature _____ Date: [ ]

Employee/Witness Signature _____ Date: [ ]

Comments: [ ]