WESTERN MICHIGAN ENT, PC
HIPAA Acknowledgement Form

I am a patient of Western Michigan ENT. I hereby acknowledge I have received and/or read Western Michigan ENT's Notice of Privacy Practices.

Name: _____ (Please Print)

Signature: _____

Date: _____

Or

I am a parent or legal guardian of _____ (patient name). I hereby acknowledge receipt of Western Michigan ENT's Notice of Privacy Practices with respect to the patient.

Name: _____ (Please Print)

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____

Date: _____

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