



HIPAA Acknowledgment Form

I am a patient of Western Michigan ENT. I hereby acknowledge I have reviewed and 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: _____