WEST COAST INFECTIOUS DISEASES

Brent W. Laartz, MD
Todd M. Groom, PhD, MD
Lily N. Jones, DO
Jennifer Patterson, DO
Alexis Parker, APRN

Patient: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT RECEIPT

The Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. I acknowledge that I have received the Notice of Privacy Practices. West Coast Infectious Diseases complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

_____
Signature of Patient or Patient's Representative Date

_____
Print Name Relationship to Patient

Interpreter (if applicable)

(FOR OFFICE USE ONLY)

Please document your efforts to obtain acknowledgement and reason it was obtained or not obtained.

- ☐ Notice of Privacy Practices Given – Patient Able to Sign
- ☐ Notice of Privacy Practices Given – Patient Unable to Sign
- ☐ Notice of Privacy Practices Given – Patient Declined to Sign
- ☐ Notice of Privacy Practices and Acknowledgement Mailed to Patient
- ☐ Other Reason Patient Did Not Sign _____

_____ _____
Signature of Office Representative Date

8607 Easthaven Court, Suite 101
New Port Richey, Florida 34655
Phone: 727-669-6800 Fax: 727-669-2540