ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received from WHASN a copy of the Notice of Privacy Practices of WHASN. I understand that the Notice of Privacy Practices sets forth my rights relating to the use and disclosure of my personal health information and explains how WHASN can use and disclose my personal health information both with and without my authorization. I further understand that I may contact WHASN's Privacy and Security Officer, the WHASN President, if I have any questions regarding the contents of this Notice or to file a complaint.

_____

Patient Name

_____ _____/_____/_____

Patient/Health Care Agent/Guardian/Relative Signature Date