Acknowledgement and

Request of Privacy Practices

By signing below, I acknowledge that I have been given the option to request a copy of the West Tennessee Hearing and Speech Center Notice of Privacy Practices I understand that my health information may be used and disclosed by the West Tennessee Hearing and Speech Center. I understand that I may obtain access and control this information.

_____

Signature of Patient or Guardian

_____

Print Name of Patient or Guardian

_____

Date

_____ **YES** I would like a copy of the West Tennessee Hearing and Speech Center Privacy Practices.

_____ **NO** I would not like a copy of the West Tennessee Hearing and Speech Center Privacy Practices.

Please list who you want to have access to your pertinent medical information.

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65 Ridgecrest Road * Jackson, TN 38305 * Phone: 731-668-6076 * Fax: 731-668-7033 * www.wthsc.com