Stony Brook
Southampton Hospital

ACKNOWLEDGEMENT OF RECEIPT OF WESTHAMPTON PRIMARY CARE'S PRIVACY PRACTICES

I, the undersigned acknowledge that I have received a copy of the Westhampton Primary Care Center's **Notice of Privacy Practices.** Should I have any questions about the policy, I will discuss them with my physician or the group's C*ompliance Officer*.

Print Name: X_____ Date of Birth: X_____

Signature: X_____ Date: X_____

AUTHORIZATION FOR THE RELEASE OF PATIENT HEALTH INFORMATION TO A SECOND PARTY

I authorize the release of my Patient Health Information to my

(Fill in name(s) of all that apply)

Spouse:_____

Family Member:_____

Friend:_____

School/College Health Svcs: _____

Other:_____

By signing below, I acknowledge that this authorization is valid until it is revoked by me.

Patient Signature:_____ Date:_____

Parent/Guardian Signature (if patient is minor):_____

Print Name of Parent/Guardian:_____