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Wendy Carannante and Associates, PLLC

High Quality and Compassionate Care

I have reviewed the HIPAA information regarding Privacy Practices, acknowledge, and understand the Privacy Practices of Wendy Carannante and Associates and its personnel. A copy of this is also available to me at any time.

Patient Name (Printed)

Parent/Responsible Party Name (Printed)

(If patient under 18 yrs. of age)

#  \* Signature of Patient Date

#  \* Signature of Parent/Responsible Party Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.) and provide proper documentation.

#  Signature of Staff Witness Date