

AzureWave Medical Services, LLC

HIPAA Acknowledgment of Receipt

I acknowledge that I have received or have been offered a copy of the Notice of Privacy Practices for AzureWave Medical Services, LLC, as required under the Health Insurance Portability and Accountability Act (HIPAA) and 45 CFR §164.520.

I understand that the Notice of Privacy Practices describes how my protected health information (PHI) may be used and disclosed for treatment, payment, healthcare operations, and other purposes permitted or required by law.

I understand that I have the right to request a copy of the Notice at any time and that it is available upon request.

By signing below, I acknowledge receipt of the Notice of Privacy Practices.

Patient Name (Print): _____

Signature: _____

Date: _____

If signed by personal representative, relationship to patient: _____