PEDIATRIC UROLOGY OF WESTERN NEW YORK, P.C.

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

I,_____, have reviewed a copy of Pediatric Urology of WNY, PC Notice of Privacy Practices.

_____ _____ _____
Patient's Name Date of Birth Signature of Parent Date

Person(s) to contact regarding appointment/medical information

Name_____ Name_____

Relationship_____ Relationship_____

Home phone( )_____ Work Phone ( )_____

Cell Phone Mom( )_____ Cell Phone Dad( )_____

Email _____ (relationship)

Appointment Information		**Medical information**	
Home phone (including auto call)?	☐	Home phone (including auto call)?	☐
Cell phone (including auto call)?	☐	Cell phone (including auto call)?	☐
Mobile text (including auto call)?	☐	Mobile text (including auto call)?	☐
Work phone? (listed above)	☐	Work phone? (listed above)	☐
With another person, if so who? (below)	☐	With another person, if so who? (below)	☐
Send via mail?	☐	Send via mail?	☐
Send via email/portal?	☐	Send via email/portal?	☐

If we are unable to reach the people listed above, please provide us with someone else we can contact.

Name_____ Relationship_____

Phone Number_____ Can we leave them a message ☐yes

Name_____ Relationship_____

Phone Number_____ Can we leave them a message ☐yes

We are unable to provide medical/appointment information to people not listed and authorized by you.

Patient Reviewed HIPAA Privacy Statement

_____
Signature of Patient or Personal Representative

*****Fill out the top portion and we will obtain your signature at your appointment.**