ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Weirton Medical Center Notice of Privacy Practices.
I understand that information **Weirton Medical Center** acquires or creates about me will only be disclosed to others for treatment, payment and health care operations as set forth in the Notice or as authorized by me in writing.

I CERTIFY THAT I HAVE READ THIS FORM OR HAD IT READ TO ME AND UNDERSTAND ITS CONTENTS.

__ _____ _____

Signature Date Witness Date

_____ Patient _____ Substitute Decision Maker

_____ _____

If Substitute Decision Make, state relationship If Substitute Decision Maker, state reason