WESTCHESTER INSTITUTE FOR HUMAN DEVELOPMENT
Cedarwood Hall
Valhalla, NY 10595-1681

NAME ______________________________

D.O.B. ______________________________

WMC # ______________ **WIHD#** ______________

(For WIHD Use Only)

NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided a copy of this *Notice of Privacy Practices* and have therefore been advised of how health information about me may be used and disclosed by the Institute and the facilities listed at the beginning of this notice, and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV-related information, alcohol and substance abuse treatment information, mental health information, and genetic information.

Signature of Patient or Personal Representative

Print Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority