Workers Assistance Program, Inc.

Acknowledgement of Receipt of Notice of Privacy Practices

Under the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) we are required to attempt to obtain your written acknowledgement of receipt of the Notice of Privacy Practices.

By signing this form, I acknowledge that I have had the opportunity to review and have been offered a copy of the WAP, Inc. Notice of Privacy Practices.

Signed: ______________________________**Date:**______________________

Print Name: ____