Windward Urology Associates Ltd
Ellerslie School Road, Black Road
St. Michael, Barbados
Tel: (246) 426-5078 - Fax: (246) 426-5079

PATIENT ACKNOWLEDGEMENT OF DISCLOSURE INFORMATION

My signature below acknowledges the following:

- I have received a copy/am aware of the Patient Bill of Rights: as required by law and have had an opportunity to receive assistance in understanding and exercising these rights.

- I have received a copy/am aware of this office's Notice of Privacy Practices, including the Private Health Information (PHI) designated at the time of the visit.

- I have received information on/am aware of the Infection Control measures utilized by this organization (in the Disclosure/Grievance Information).

- I have received a copy/am aware of the Practice Disclosure (about our Practice, Including the Grievance process) and am comfortable with that information. I also understand this practices position on **Do NOT Resuscitate (DNR)** and **Living Wills** and that this practice does not honor these directives.

Signature of Patient/Representative _____ Date_____

Above signature was not obtained because:

○ Patient is unable and unaccompanied by a representative. Patient left with all

○ pertinent disclosures.

○ Patient refused to sign.

○ Patient refused forms