



NOTICE OF PRIVACY POLICY-ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see a copy of that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our office at (360) 574-9730.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge that I am aware of the **Notice of Privacy Practices** but decline a full copy of them at this time. I understand that I may request and receive a copy at any time.

Print Patient Name

Date

Patient Signature/Responsible Party Signature

Relationship

OR

By my signature below I acknowledge the receipt of the **Notice of Privacy Practices**.

Print Patient Name

Date

Patient Signature/Responsible Party Signature

Relationship

This form will be retained in your medical record.