NOTICE OF PRIVACY PRACTICES —ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy 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 Glynis Thakur, Privacy Officer, at (425) 338-4000.

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.

In addition to the allowable disclosures described in the Notice of Privacy Practices, I hereby specifically authorize disclosure of my protected health information to the person(s) indicated below:

☐ NO DISCLOSURE TO ANY PERSON OTHER THAN MYSELF

Name of friend/relative:	Relationship:	Yes	No Disclosure

*Washington State requires minors to release their information to their immediate family unless a legal document is produced that covers extenuating circumstances

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

____ _____________

Printed patient name Date of birth

____ _____________________________

Legally authorized ***printed*** name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative)

____ _____________ _____________

Patient or legally authorized individual ***signature*** Today's date Time

Per HIPAA guidelines this must be updated yearly. (Even if the information has not changed)

This form will be retained in your medical record.

Last Update: 07/16/2015