Gig Harbor Naturopathic Medicine, PS

6659 Kimball Drive Suite C306
Gig Harbor, WA 98335
(253)851-7550

Acknowledgement of Privacy Practices

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly or indirectly

- Obtain payment from third-party payers for my health care services

- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my health care provider's *Notice of Privacy Practices* that contains a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of said *Notice of Privacy Practices.*

I understand that my health care provider has the right to change the *Notice of Privacy Practices* at any time, and that I may contact this office at the address above to obtain a copy of the current *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations, and that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

X _____   _____
    Patient's Signature   Date

X _____   _____
    Guardian/Representative's Signature   Date

_____
Relationship to Patient/Representative Authority

OFFICE USE ONLY

Unable to Obtain Acknowledgement

This section serves as a record of the above practitioner's good faith effort to obtain written acknowledgement of receipt from the patient for the Notice of Privacy Practices. Patient was given a copy of the notice on: _____.

___☐ Patient refused to sign acknowledgement.

___☐ Patient is physically unable to sign acknowledgement.

___ Other: _____