

Issaquah Obstetrics & Gynecology, PLLC

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT

We keep a record of 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 the Office Manager.

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 receipt of the Notice of Privacy Practices.

Patient or legally authorized individual signature

Date

Time

Print Name

Printed Name if signed on behalf of the patient

Relationship (parent, legal guardian)

If you want to give permission to our clinic, for someone other than yourself to be notified of your health information, please indicate their name and relation below.

Name: _____

Relation to patient: _____

I authorize the above named individual to correspond with Issaquah Obstetrics & Gynecology regarding my health information.

This authorization ends: (please check one)

1) 90 days from the date signed.

2) On date: _____

3) When notified by patient

Patient Signature

Date

This form will be retained in your medical record.