MT RAINIER CLINIC
Reach New Heights in Good Health Naturally

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Acknowledgement and Receipt of Notice of Privacy Practices

Our Notice of Privacy Practice provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this acknowledgement. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by submitting a request.

By signing this form, you acknowledge receipt of our notice regarding use and disclosure of protected health information about your treatment, payment and health care operation as described in the notice.

I authorize Mount Rainier Clinic to leave messages at the contact listed below, (such as confirmation calls and test results.)

☐ Home Phone_____ ☐ Mobile Phone_____

☐ Work Phone_____ ☐ Email_____

HIPAA Release of Information:

Please list anyone you want to have verbal and/or physical access to your health care information. This information will remain in place until you direct Mount Rainier Clinic otherwise

Name:	**Relationship:**	**Phone Number:**

Emergency Contact:

Please list your emergency contact if different from above.

Name:	**Relationship:**	**Phone Number:**

Patient Name_____

Patient/Representative Signature_____

Date_____

For Office Use Only:

I have attempted to obtain the patient's signature on this form, but was not able to obtain it for the reason listed below:

Reason:_____Staff member initials:_____Date:_____

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