

BIRTH & FAMILY CLINIC

21911 76th Ave. W., Suite 110 Edmonds, WA 98026
Phone: 425-640-4950 Fax: 425-640-4958

Acknowledgment of Receipt of Privacy Notice

Patient Name (Please PRINT)

Date of Birth

1. With my initials below, I acknowledge that I was offered and/or provided with a copy of the Notice of Privacy Practices for Birth & Family Clinic.

Initial Here: []

2. I authorize Birth & Family Clinic to contact me with my **CONFIDENTIAL** information regarding treatment or test results at the following numbers:

Please leave at least one number where we could leave you a message.

- Home Number: () Voicemail OK? Yes No
- Cell Number: () Voicemail OK? Yes No
- Work Number: () Voicemail OK? Yes No

3. I authorize Birth & Family Clinic to discuss my protected health information, including medical history, current conditions, treatment, and test results with the following individuals:

- Patient Only**
- Spouse or Significant Other**
Name: _____
- Parent(s)**
Name: _____
Name: _____
- Other**
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

4. I authorize Birth & Family Clinic to discuss my billing information with the above noted individuals.

- Yes No

X _____
Signature Relationship to Patient Date

This authorization is valid for one year (1) following the date signed above unless withdrawn in writing to Birth & Family Clinic.