Acknowledgement of Privacy Practices

Lindsay A Wais, N.D.
465 Rainier Blvd. N. Suite A
Issaquah, WA 98027

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 and 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 Naturopath's *Notice of Privacy Practices* containing 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 such *Notice of Privacy Practices*. I understand that my Naturopath has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *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 I understand 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.

Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____

I authorize the Absolute Wellness Clinic to release medical information, test and procedure results, appointment information, or other health information to the following individuals:

1. _____ Relation to Patient: _____

2. _____ Relation to Patient: _____

By signing below I also indicate that I understand that any contact made with Dr. Wais through email is not a secure form of communication and I release Dr. Wais of responsibility concerning any problems that may occur through email communications.

Signature: _____ Date: _____