

Seattle Medical and Wellness Clinic (SMAWC)
1325 Fourth Avenue, Suite 1240
Seattle, Washington 98101
206-625-0202

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Seattle Medical and Wellness Center (SMAWC). The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Seattle Medical and Wellness Center (SMAWC) reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

| ADDITIONAL DISCLOSURE AUTHORITY | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|-----|--------------------------|----|
| In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below. | | | | |
| ANY MEMBER OF MY IMMEDIATE FAMILY | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| SPOUSE ONLY | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| OTHER (PLEASE SPECIFY): | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |

Name of Patient or Personal Representative

Signature of Patient or Personal Representative

 Date

 Description of Personal Representative's Authority

OFFICE USE ONLY BELOW THIS LINE

| Record of Acknowledgement not obtained | | | | |
|----------------------------------------|--------------------------|------------------------------------------------------------|--------------------------|----|
| PROVIDED PRIOR TO TREATMENT? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| DATE PROVIDED: | | | | |
| REASON FOR DENIAL: | <input type="checkbox"/> | NEEDED MORE TIME TO REVIEW STATEMENT OF PRIVACY PRACTICES. | | |
| | <input type="checkbox"/> | WANTED TO CONSULT WITH ANOTHER PERSON, BEFORE SIGNING. | | |
| | <input type="checkbox"/> | UNABLE TO SIGN. | | |
| | <input type="checkbox"/> | REASON NOT GIVEN. | | |
| | <input type="checkbox"/> | OTHER (EXPLAIN): | | |