ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Skin Cancer Center of Bellevue
1135 116th Ave NE #350
Bellevue, WA 98004

Skin Cancer Clinic of Seattle
1801 NW Market ST #107
Seattle, WA 98107

Skin Cancer Center of Burien
13512 Ambaum Blvd SW #100
Burien, WA 98146

Skin Cancer Center of Issaquah
751 NE Blakely Dr, Ste 5010
Issaquah, WA 98029

Northwest Skin Cancer Center
20696 Bond Rd NE #110
Poulsbo, WA 98370

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 Skin Cancer Clinic of Seattle'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 Skin Cancer Clinic of Seattle 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 (if you are the patient, please write "self"): _____

If you wish to allow our office to discuss either your treatment or financial information with anyone other than your referring doctor and/ or your insurance carrier, please indicate who you authorize us to speak to by checking the appropriate box(s) below.

□ **Spouse/ Partner** (Please indicate name of person: _____)
□ **Mother/ Father** (Please indicate name of person: _____)
□ **Family Member(s)** (Please indicate name of person: _____)
□ **Friend/ Other** (Please indicate name of person: _____)

For Office Use Only:
We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

□ The patient refused to sign
□ Communication barriers
□ Emergency situation
□ Other