Institute of Complementary Medicine
1600 E Jefferson Street, Suite 603
Seattle, WA 98122-5649

Notice of Privacy Practice 2019

NOTICE OF PRIVACY PRACTICE- ACKNOWLEDGEMENT

We keep record of the health care service we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the office manager.

Our Notice of Privacy describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below, I acknowledge receipt of the Notice of Privacy Practices from the Institute of Complementary Medicine.

Patient or legally authorized individual signature: : _____

Patient name if signed on behalf of patient: : _____

Relationship: * ☐ Patient ☐ Personal Representative ☐ Legal Guardian

Today's Date: _____

This form will be retained in your medical record.