ACKNOWLEDGEMENT
OF
PRIVACY RIGHTS

Dan Tennenbaum L. Ac.; OMD
14810 Lake Hills Blvd # A-2
Bellevue, WA 98007
425-373-1416

My signature confirms that I have been informed that I have rights to privacy regarding my protected health information, and I have been given the opportunity to review this office's *Notice of Privacy Practices* as required by the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

- Provide and coordinate treatment among health care providers who may be involved in my care
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations

Patient Name:_____Date:_____

Signature:_____

Relationship to Patient:_____

Dependent family members also covered by this acknowledgement:_____

_____

For office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Rights due to the following reason:

- ☐ The patient refused to sign
- ☐ Communication barriers
- ☐ Emergency situation
- ☐ Other