

N.E. WASHINGTON HEALTH PROGRAMS

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

____ I have been offered the 4-page Notice of Privacy Practices document and **have read the material.**

____ I have read the 4-page Notice of Privacy Practices document before and **choose not to read it at this time.**
I know that I may ask for a copy to read at any time.

Initials

PERMISSION TO RELEASE INFORMATION

____ I **authorize** N.E. Washington Health Programs (NEWHP) to mail or leave detailed messages regarding appointments, lab results or follow-up information to individuals answering my home phone number and/or my answering machine or voice mail system.

____ I **authorize** N.E. Washington Health Programs (NEWHP) to mail or leave detailed messages regarding appointments, lab results or follow-up information at the following **alternate phone number or mailing address.**

Alternate phone: _____

Alternate address: _____

Initials

Please list the names and relationship of **persons authorized by you to receive your health information** verbally, pick up prescriptions on your behalf or pick up medical record information.

Name

Relationship

****The patient assumes responsibility for updating information as changes occur.**

Initials

CONSENT FOR PHOTOGRAPH

____ I **consent and authorize** N.E. Washington Health Programs (NEWHP) to photograph me to assist in patient identification or copy my picture identification for healthcare purposes only.

Initials

Signature

Date

Printed name

Witness