Associates In Mental Health Administrative Office
1116 Key St Ste 204 Bellingham, WA 98225
(360) 715-2488 Phone
(360) 671-1842 Fax

WASHINGTON NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I keep a record of the health care services I provide you. The Washington Notice Form 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 Washington Notice Form of Privacy Practices that went into effect April 14, 2003: _____
(initials)

I chose not to receive a copy of the Washington Notice Form of Privacy Practices that went into effect on April 14, 2003: _____
(initials)

_____/_____/_____
Signature of Patient or legally authorized individual Date

_____
Relationship (self, parent, legal guardian, personal representative)

_____
Printed Name

_____
(Notation, if any, by staff)

_____/_____/_____
Staff Signature Date

THIS FORM WILL BE RETAINED IN YOUR MEDICAL RECORD