## Notice of Privacy Practices Acknowledgment

**Bellingham Bay Ophthalmology, PLLC** has a responsibility to protect the privacy of your health care information and to provide a Notice of Privacy Practices that describes how your health care information may be used and disclosed, how you can access your health care information, and whom to contact if you have questions, concerns, or complaints.

We may change the Notice of Privacy Practices at any time, and you may contact **Bellingham Bay Ophthalmology, PLLC** at (360) 647-7750 to obtain a current copy of the Notice of Privacy Practices or to ask questions.

**By my signature below, I agree that I have received the Notice of Privacy Practices of Bellingham Bay Ophthalmology, PLLC .**

_____

Printed name of patient

_____

Patient or legally authorized individual's signature Date Time

_____

Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative)

This form will be retained in your medical record.

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In addition to the allowable disclosures described in the "Notice of Privacy Practices", I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

Any member of my immediate family: Yes ____ No ____
Other (please specify) Yes -___ No____

_____

May we leave messages on your home telephone or cell phone regarding your health care and appointment information? Yes ____ No____

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***For Office Use Only:***

Office staff complete below:
I have attempted to obtain the patient's signature on this form, but was not able to obtain it for the reason(s) listed below:

Date: _____ Staff member initials: _____

Reasons: _____