HIPPA NOTICE OF PRIVACY PRACTICE AND CONSENT/WRITTEN ACKNOWLEDGEMENT

ALL NATUROPATHIC CLINIC

9989 SW Nimbus Avenue
Beaverton, Oregon 9708

I hereby consent to the use and disclosure of my protected health information by practitioner, ***Dr. Mai Nguyen Pham***, at the **All Naturopathic Clinic** for the purposes of treatment, payment, and healthcare operations, or as otherwise required by law.

- I acknowledge that I have the right to review and receive a printed copy of the Notice of Privacy Practices provided by the practitioner, ***Dr. Mai Nguyen Pham***, at the **All Naturopathic Clinic**, prior to signing this consent. The Notices of Privacy Practices describes how medical information about me may be used and disclosed, and how I can access this information.
- I have the right to request restrictions on the usage and disclosure of my protected health information.
- I have the right to request an alternative to communication of my protected heath information.
- I understand that if I wish to revoke this consent, I will do so in writing and submit it to the address listed above. I understand that the practitioner, ***Dr. Mai Nguyen Pham***, at the **All Naturopathic Clinic** may honor these requests; they are not required by law to do so. I also understand that revocation will be honored as of the date it is received by practitioner, ***Dr. Mai Nguyen Pham***, at the **All Naturopathic Clinic**.
- I understand that if I have any complaints, I can submit them in writing to the address above or contact the practitioner, Dr. Mai Nguyen Pham, at the **All Naturopathic Clinic**, by phone at: (503) 644-7100.
- I am aware that the practitioner, ***Dr. Mai Nguyen Pham***, at the **All Naturopathic Clinic** reserves the right to change the terms of their Notice of Privacy Practices and to make a new notice of Privacy Practices provisions effective for all protected health information that she maintains. In the event of amendments, the practitioner, ***Dr. Mai Nguyen Pham***, at the **All Naturopathic Clinic** will make available a revised Notice of Privacy Practices for my review.

Patient Signature: _____ Date: _____
Parent/Guardian/Responsible Party:_____ Date: _____

This section to be completed by practitioner, if unable to obtain written acknowledgement from patient.

I made a good faith effort to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above named patient, but was unable to because:

☐ Patient declined to sign tis written acknowledgement

☐ Other Specify _____.

Name of Employee: _____ Title: _____ Date: _____