Northwest Dermatology & Skin Cancer Clinic

Acknowledgement of Notice of Privacy Practices and Authorization to Use and Disclose PHI for Payment Purposes

We keep a record of the health care services we provide you. You may ask to see and copy that record and to correct it. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so.

Washington State requires authorization to use or disclose protected health information for payment purposes.

You may get more information about it by contacting
Carol McAfee, Administrator (425/774-2616)

Our **Notice of Privacy Practices** 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 Notice of Privacy Practices.

Patient or legally authorized individual signature	Date	Time

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

I authorize treatment of the person named above, and authorize my insurance benefits to be paid directly to Northwest Dermatology & Skin Cancer Clinic for any services furnished to me by a Northwest Dermatology provider. I accept responsibility for payment of all services received from Northwest Dermatology & Skin Cancer Clinic, and understand that a finance charge of up to 1% (minimum $5.00) will be assessed for balances over 60 days. I authorize the use and disclosure of personal health information for purposes related to payment for services.

Patient or legally authorized individual 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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