ARTHRITIS NORTHWEST, PLLC
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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

PLEASE SELECT FROM THE FOLLOWING:

- ☐ YES, you have my permission to leave routine test results or information on my voicemail.
- ☐ NO, you DO NOT have permission to leave routine test results or information on my voicemail.
- ☐ YES, you have my permission to speak with the following family members **Please print name(s) and relationship:

  _____

- ☐ YES, you may send information, lab or other test results to me through the Patient Portal (uses internet and email).

  Email Address: _____

Arthritis Northwest, PLLC has a responsibility to protect the privacy of your health care information and to provides 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 our office at (509) 838-6500 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 Arthritis Northwest, PLLC.

X _____ _____
PRINTED NAME OF PATIENT — DATE OF BIRTH

X _____ _____
PRINTED NAME IF SIGNED ON BEHALF OF THE PATIENT — TODAY'S DATE

X _____ _____
PRINTED NAME IF SIGNED ON BEHALF OF THE PATIENT — RELATIONSHIP (PARENT, LEGAL GUARDIAN, PERSONAL REPRESENTATIVE)

This form will be retained in your medical record. Witnessed by: ANW Staff: _____ Date: _____

FOR OFFICE USE ONLY

Office staff completes the section if not signed by patient above. ANW Staff: _____ Date: _____

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:

_____

_____

_____