NOTICE OF PRIVACY PRACTICES - ACKNOWLEDGMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. 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. You may see your record or get more information about it by contacting Deborah Sullivan.

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 on behalf of the patient) relationship

<u>In addition</u> to myself, I authorize Spokane Urology to share my healthcare information with the following individuals:

_____

Name relationship

_____

Name relationship

_____

Name relationship

I do not wish to have my healthcare information shared with any individuals.

_____ _____

_____ Patient (or legally authorized individual) signature date time

This form will be retained in your medical record