

# Northwest Health & Healing Center

1515 NW 9th Street Corvallis, OR 97330

(541) 754-2225

## RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature acknowledges that I have access to Northwest Health & Healing Center's Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by Northwest Health & Healing Center and of my rights with respect to my health information.

I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.

*Patient's Signature:* \_\_\_\_\_ *Date:* \_\_\_\_\_

*Patient Name:* \_\_\_\_\_

### **TO BE COMPLETED BY ADMITTING STAFF MEMBER IF FORM IS NOT SIGNED**

- Was the patient provided with a copy of the Notice of Privacy Practices?
  - Yes
  - No
- Briefly describe efforts made to obtain the patient's acknowledgment of receipt of the Notice and explain why the patient was not able or willing to sign this form: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Staff Member: \_\_\_\_\_ Date: \_\_\_\_\_