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nwnaturopathicmedicine

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HIPAA Privacy and Release of Information Authorization

I understand that under the Health Insurance Portability & Accountability Act ("HIPAA"), I have certain rights to privacy regarding my protected health information.

I understand that as part of my healthcare, NW Naturopathic Medicine originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment.

I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information.

I understand that NW Naturopathic Medicine has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Private Practices.

Signature:
_____

Date: _____