Dr. Jessica Corbeille, ND, CES
Dr. McKenzie J. Timmer, ND
Elevated Natural Health Center, PLLC
1500 Westlake Ave N Suite 120
Seattle, WA 98109
P: 206.566.7225 | F: 833.264.5894

Acknowledgement of Receipt and Review of the Notice of Privacy Practices

The Notice of Privacy Practices provides information about how we may use or share your protected health information. You have the right to review this notice before signing and a right to request a copy of this notice at any time. The terms of this notice may change at any time, provided these changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

By signing below, you are acknowledging that you have received a copy or read a copy of the Notice of Privacy Practices. By signing, you are *not* agreeing to any special uses or disclosures of your health records. Please note, if you refuse to sign, this does *not* prevent a provider or plan from using or disclosing health information as HIPAA permits, but a record of this fact will be kept.

If you have any questions or concerns about the Notice of Privacy Practice or HIPAA guidelines, please do not hesitate to ask your provider or staff at Elevated Natural Health Center, PLLC.

Email and Phone:
Since email and voicemail are not considered "secure" communication methods and are not HIPAA compliant:

- May we leave messages for you on your cell phone? Cell number: _____ YES / NO _____ (initial)
- May we contact you at via email? Email address: _____
  YES / NO _____ (initial)

HIPAA Release of Information:
I authorize the following people to have access to my record at Elevated Natural Health, LLC which includes all protected health information:

1) _____ Relationship: _____
2) _____ Relationship: _____
3) _____ Relationship: _____
4) _____ Relationship: _____

I certify that I have read the above regarding the Notice of Privacy Practices.

_____
Printed name

_____ _____
Signature Date

For Office Use Only:
I have attempted to obtain the patient's signature on this form, but was not able to for the reason listed below:

Reason: _____ Staff member initials: _____Date:_____