LAURAL J SCHABERG, ARNP
KRIS CHATMAN, ARNP
1628 South Mildred St, Suite 105, Tacoma, WA 98465

PRIVACY PRACTICES ACKNOWLEDGEMENT

Please Read The Following Statements Carefully
A copy of our Notice of Privacy Practices will be provided for your review upon request. By signing this form you consent to the use and disclosure of your protected health information necessary to carry out treatment, payment activities and general healthcare operations.

Your Rights

You have the right to revoke this consent at any time by giving us written notice of your revocation submitted to this office as listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation and that we may decline to treat you or to continue to treat you if you revoke this consent.

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775 or Visit **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Please check how we may communicate regarding health information or appointment reminders.
I wish to be contacted in the following manner (check or type an x all that applies):

Home Telephone
____ Leave message with detailed information
____ Leave message with callback number only

Written Communication
____ mail to home address
____ Fax to this number ____________

May we contact you at work? Yes ____ No____

Work telephone number
_____ Leave message with detailed information
_____ Leave message with callback number only

Cell Phone
___ Leave message with detailed information
___ Leave message with callback number only

I hereby give permission to Laural J Schaberg ARNP/Kris Chatman ARNP, PNWPC to disclose information regarding treatment to:
(please list by name & relationship)

Spouse/Partner____________________ Son/Daughter_____________________

Others ____

I hereby acknowledge receipt of the Notice of Privacy Practices and have had full opportunity to read and consider the contents of this Consent form and the Notice of Privacy practices. I understand that, by signing this consent form. I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations

NAME (printed) ______________________________ Birth date ____________

Signature____Date________________