Chad Aschtgen, ND, FABNO
Erica Joseph, ND, L.Ac, FABNO
Jenna K. Bailey, ND

# Acknowledgement of Receipt of "Notice of Privacy Practices"

I acknowledge that I have received a copy of *Seattle Integrative Oncology*'s "**Notice of Privacy Practices**" detailing how my health information may be used and disclosed under federal and state law.

I wish to have the following restrictions to the use or disclosure of my health information:

________________________________________________________________

________________________________________________________________

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________________________________________________________________

| ____________________ | ____________________ | ________ |
|---|---|---|
| *Print Patient's Name* | *Patient's Signature* | *Date* |
| ____________________ | ____________________ | ________ |
| *Print Name of Guardian or Responsible Party* | *Signature of Guardian/Responsible Party* | *Date* |

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FOR OFFICE USE ONLY

- ☐ Patient refused to sign *Acknowledgement of Receipt of Privacy Practices*
- ☐ Patient was unable to sign *Acknowledgement of Receipt of Privacy Practices* due to reasons specified below.

________________________________________________________________

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________________________________________________________________

| ____________________ | ____________________ |
|---|---|
| *Provider's Signature* | *Date* |

***Providence Integrative Cancer Care***
Providence Regional Cancer System – Olympia
t: 360.412.8951 | f: 844.772.0665

***Seattle Integrative Oncology***
2859 Eastlake Ave E. – Seattle
t: 206.739.7447 | f: 844.883.0052

***Providence Integrative Medicine***
Providence Regional Cancer Partnership – Everett
t: 425.297.5500 | f: 844.772.0975