INTERLAKE MEDICAL CENTER
2103 152nd Avenue NE
Redmond, WA 98052
425-746-2400 Fax 425-746-2659

Norman H. Leou, M.D.
Garrett P. Yam, M.D.

Jackline S. Joseph, M.D.
John I. Yam, M.D.
Srobona Mitra, M.D.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Your doctor keeps a record of the health care services he/she provides you. You may ask to see and get a copy of that record. You may also ask to correct that record. Your doctor will not disclose your record to others unless you direct him/her to do so or unless the law authorizes or compels him/her to do so. You may see your record or get information about it by contacting the HIPAA Privacy Officer.

The Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

I _____Print Name_____allow appropriate **Personal Health Information** (PHI) to be released as follows (Please check the following).

- ❑ **Messages regarding PHI may be left at my**
  - **Home Phone # (_____)_____**
  - **Work Phone # (_____)_____**
  - **Cell Phone # (_____)_____**
  - **Other Phone # (_____)_____**
  - **Please indicate preferred number you wish us to use (circle):**
  - **CELL / HOME / WORK / OTHER**

- ❑ **PHI may be faxed to me at the following # (_____)_____**

- ❑ **PHI may be released to my**

  Spouse (name) _____

  Other (name) _____

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

_____

Patient or legally authorized individual signature Date

_____

Printed name if signed on behalf of the patient Relationship

This form will be retained in your medical records.
Last update 02-23-2012