Corina B. Going, ND, PLLC
Naturopathic Physician ◆ Classical Homeopath
6212 75th Street West Lakewood, Washington 98499
(253) 983-8507 fax: (253) 983-8576

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I, _____, hereby acknowledge that Dr. Going's office has provided me with access to a copy of its Notice of Privacy Practices that describes how medical and/or psychological information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints that I may contact the office at 253-983-8507.

I also understand that I am entitled to receive updates upon request if Dr. Going's office amends or changes its Notice of Privacy Practices in a material way.

I hereby designate the following individual(s) to receive communications from Dr. Corina Going that may include health information about me:

_____ _____ _____
(Name) (Relationship to Patient) (Phone Number)

I authorize Dr. Corina Going and staff to leave voice mail messages concerning my health information (I.E. lab results, appointment instructions, etc.) at the following number:

Phone: _____ Patient Initials: _____

_____ _____
(Signature of Patient or Parent/Guardian) (Relationship to Patient)

_____
(Date)

THIS SECTION IS TO BE COMPLETED BY DR. GOING'S OFFICE IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMENT FROM THE PATIENT.

I made a good faith effort to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

_____ Patient declined to sign this written Acknowledgement.
_____Other (specify)

Name and Title of employee_____
Date_____