Hybrid Organization

Notice of Privacy Practices Acknowledgment

I understand that under the Health Insurance Portability and Accountability Act (HIPPA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of the Tulalip Tribes Notice of Privacy Practices effective date 5/15/2015. I also understand that the Tulalip Tribes has the right to change its Notice of Privacy Practices and that I may contact the Tulalip Tribes at any time to obtain a current copy of the Notice of Privacy Practices.

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Patient Name (please print)

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Patient Date of Birth

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Signature of Patient/Legal Guardian

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Date of Signature

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Legal Guardian (printed name) if applicable