

**Dr. Stuart Rich**  
**1348 8th ST NE**  
**Auburn, WA 98002**  
**(253)939-6900**

**ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES**

I, \_\_\_\_\_ have received and understand the practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices and to make changes regarding all protected health information resident at, or controlled by, this practice. If changes to the policy occur, this practice will provide a revised Notice of Privacy Practices upon request.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Date of Birth \_\_\_\_\_

\*\*Relationship to patient if signed by a personal representative of patient:

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**ADDITIONAL DISCLOSURE AUTHORITY**

In addition to the allowable disclosures described in the Notice of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

Any member of my immediate family \_\_\_yes \_\_\_no

Spouse only \_\_\_yes \_\_\_no

Other(please specify) \_\_\_\_\_ \_\_\_yes \_\_\_no