TULALIP HEALTH SYSTEM

Hybrid Organization

Notice of Privacy Practices Acknowledgment

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), 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.

_____ _____

Patient Name (please print) **Patient Date of Birth**

_____

Legal Guardian (printed name) if applicable

_____ _____

Date of Signature **Signature of Patient/Legal Guardian**