Tulalip Health Clinic
Tulalip Clinical Pharmacy
Tulalip Behavioral Health

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 5/15/15. 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 (print) Patient Date of Birth

_____ _____
Signature of Patient/Legal guardian Date of Signature

_____
Legal guardian (Printed name) if applicable

Clear Form Print Form