

**Woodinville Physical Therapy**  
**17000 140<sup>th</sup> Ave. N.E., Suite #303**  
**Woodinville, WA 98072**  
**(425) 481-1744**

**NOTICE OF PRIVACY PRACTICES-ACKNOWLEDGEMENT**

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your records to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the Privacy Officer-Stephanie Proffitt.

Our **Notice of Privacy Practices** are located at the front desk for you to take a copy for your records. This describes in more detail how your health information may be used and disclosed, and how you can access your information.

**I acknowledge receipt of the Notice of Privacy Practices of Woodinville Physical Therapy.**

\_\_\_\_\_  
Patient or Personal Representative Signature

\_\_\_\_\_  
Date

Please include the names of persons with whom we are allowed to discuss your billing information and/or condition:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

I authorize Physical Therapy Clinics, Inc. to discuss my billing information and/or condition with the above named person(s).

\_\_\_\_\_  
Patient or Personal Representative Signature

\_\_\_\_\_  
Date

**May we leave a detailed message at any of the phone numbers you provided, either on your answering device or with whoever answers the phone?**

\_\_\_\_\_ Yes

\_\_\_\_\_ No

**This form will be retained in your medical chart.**