Dr. Courtney Johnson MD 360-440-8376
3623 SW Alaska St Seattle, WA 98126 trivasfamilymedicine.com

ACKNOWLEDGEMENT OF PRIVACY PRACTICES (HIPAA)

We want to inform you of the rights you have as a patient under the Health Insurance Portability & Accountability Act of 1996 (HIPAA).

Under HIPAA, I understand that my personal information may be used to:

● Provide and coordinate my treatment among a number of healthcare providers who may be involved in my treatment directly or indirectly

● Obtain payment from third-party payers for my healthcare services

● Conduct normal healthcare operations such as quality assessment and improvement activities

I have been informed of Trivas Family Medicine's Notice of Privacy Practices and understand that I may request a copy of this Notice for my own use. I understand that Trivas Family Medicine, PLLC has the right to change the Notice of Privacy Practices and that I may contact this office to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I further understand that Trivas Family Medicine is not required to accept my requested restrictions, but if they are accepted then I understand that Trivas Family Medicine will honor my request unless it is an emergency.

I further understand that I have the right to not sign this acknowledgement in order to receive treatment at Trivas Family Medicine.

Authorization to Communicate Protected Health Information - Check all that apply:

❑Trivas Family Medicine may leave a detailed message on voicemail at my home #: (_____)__________________

❑Trivas Family Medicine may leave a detailed message on voicemail at my cell #: (_____)____________________

❑Trivas Family Medicine may speak with another person (spouse, family member) about my medical condition:

❑Including/ ❑excluding information related to:

❑mental/behavioral health _____________ Initial

❑substance abuse _____________ Initial

❑sexually transmitted disease and reproductive medicine _____________ Initial

❑HIV status _____________ Initial

Information may be released to:

Name/Relation: __________________________________ Phone #: (_____) __________________

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the instructions above will be honored until revoked by me in writing. It is my responsibility to notify Trivas Family Medicine should I change one or more of the telephone numbers listed above.

____ ____________ ___________

Signature Today's Date Date of Birth

____

Printed name

______________________________________ ____

Parent or Guardian Name Relation to Patient