Metamorphe Health Clinic
3976 E. Harbor Road
Langley, WA 98260
360-221-2050

Mailing address:
P. O. Box 1072
Freeland, WA 98249

Acknowledgment of Receipt of Privacy Practices (HIPPA)

Susan E. Azar, ND

I, (print name)_____, patient of the above mentioned provider, do hereby acknowledge receipt/offer of a copy of this providers Notice of Privacy Practices.

Signature: _____ Date: _____

I, _____ do by give permission to give my health care information to the following person(s). _____ _____

AUTHORIZATION TO LEAVE PERSONAL HEALTH INFORMATION TO THE FOLLOWING:

o May send an e-mail message _____ E-Mail address

o May leave a detailed msg on voicemail _____ Home phone number

o May leave a detailed msg on voicemail at work _____ Work phone number

o May leave a detailed msg on cell phone _____ Cell phone number

o May leave a detailed msg at different location _____ Phone number and location

o May leave a detailed msg with spouse/partner _____ Name of spouse/partner

o May leave a detailed msg with other family member_____Name & relationship

By signing below, I understand and acknowledge that this information will be kept in my medical record and the above information will be abided by until revoked by me in writing. It is my responsibility to notify my health care provider should I change one or more of the telephone numbers listed above.

Signature_____ Date _____