

**SOUND INPATIENT PHYSICIANS, INC.**  
**ACKNOWLEDGMENT OF**  
**RECEIPT OF NOTICE OF PRIVACY PRACTICES**

By signing below, I acknowledge that I have received a copy of Sound's Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time and that I may obtain a revised copy of the Notice by calling 253-682-6020, by visiting Sound's website at [www.soundphysicians.com](http://www.soundphysicians.com), or by requesting one at Sound.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

*If you are not the patient, please fill out the following information:*

Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

*Please furnish a copy of any conservator/guardianship papers with this form.*