3240 NE 3rd Avenue ~ Camas, WA 98607

Purpose of this form:

The purpose of this form is to document the Lacamas Medical Groups Privacy practices were given to you, the patient or their personal representative as required by federal law.

My signature acknowledges receipt of Lacamas Medical Group's privacy practices.

Patient Printed Name:_____

Date of Birth:_____

Signature:_____

Date Signed:_____

If not signed by patient, then relationship to patient/Name:

HIPPA form on file at Lacamas Medical Group office. If you would like a hard copy for yourself, just ask the staff at your next appointment