Notice of Privacy Practices
Patients Rights and Responsibilities

By signing below, I hereby acknowledge receipt of Salish Cancer Center's Notice of Privacy Practices and Patient Rights and Responsibilities, and consent to its uses and disclosures described in the Notice and Rights.

Patient Name (please print)	Date of Birth
Patient Signature	Date of Signature
Authorized Representative Signature	Date of Signature
Authorized Representative Name & Relationship to Patient (e.g. Parent/Guardian, Power of Attorney)	Contact Phone

Staff Use Only:

Healthcare Provider Witness Name	Job/Title
Healthcare Provider Witness Signature	Date of Signature

Updated:04/2021