SOUND INPATIENT PHYSICIANS, INC.
AND ITS AFFILIATED COVERED ENTITIES
STATEMENT OF DISAGREEMENT FORM

PATIENT'S NAME: _____

ADDRESS: _____

DATE OF DENIAL OF AMENDMENT: _____

REASONS FOR DISAGREEING WITH DENIAL:

SIGNATURE: _____ **DATE:** _____

All Statements of Disagreement must be submitted in writing to:

Julie Seitz, Privacy Officer
Sound Inpatient Physicians, Inc.
1123 Pacific Avenue
Tacoma, WA 98422

Note: *Statements of Disagreement are limited to this page only. Additional pages will not be accepted.*