Primary Care of Cedar Hill-Pacific
319 N. First St.
Phone: (636)271-3500 Pacific, MO 63069 Fax: (636) 529-0699

NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGEMENT

A Notice of Privacy Practices (NPP) is provided to all patients and explains: (1) how your Protected Health Information (PHI) may be used or shared; (2) your rights to access or amend your PHI, request information on disclosures of your PHI, and request additional restrictions on our uses and disclosures of PHI; (3) your rights to complain if you believe your privacy rights have been violated; and (4) our responsibilities for maintaining the privacy of your PHI.

- I acknowledge that I have received a copy of the "Notice of Privacy Practices" (Version 3 August 2013 dated 09/23/2013) that explains when, where, and why my Protected Health Information (PHI) may be used or shared.
- I authorize Primary Care of Cedar Hill-Pacific to furnish complete information, including Protected Health Information, requested by my insurance carrier or its intermediaries regarding services rendered. I hereby authorize my insurance carrier to furnish to Primary Care of Cedar Hill-Pacific any information obtained in the adjudication of any claim for services furnished to me by Primary Care of Cedar Hill-Pacific.
- I acknowledge that Primary Care of Cedar Hill-Pacific, the physicians, the nurses, and other staff may obtain and share any or all of my Protected Health Information, including prescription history, with other health care professionals in order to treat me, coordinate my care, and/or in order to arrange for payment of my bill and respond to any issues related to my care.
- I acknowledge that I have the right to request additional restrictions on the use and disclosure of my PHI if I so choose.

Name of Patient/ or Guardian (if Minor): _____

Signature of Patient/or Guardian: _____ Date: _____

PATIENT COMMUNICATION CONSENT

We may need to contact you regarding your medical care. This is to acknowledge that you authorize Primary Care of Cedar Hill-Pacific to (**check all that apply**):

I consent to the following: ☐ Medication History Consent ☐ Immunization Sharing

☐ Health Information Exchange ☐ Consent to all

☐ Leave a detailed message on voice mail/machine ☐ Call my workplace phone number and leave a message

☐ Call my workplace phone number and speak only to me ☐ Transmit and Receive messages through Patient Portal

I further authorize the disclosure of my PHI to the following individuals or family members:

Name: _____ Relationship to Patient:_____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient:_____

Signature of Patient/Guardian: _____ Date: _____