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 read the foregoing and 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 St. Francis Medical Group 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 St. Francis Medical Group any information obtained in the adjudication of any claim for services furnished to me by St. Francis Medical Group.
- I acknowledge that St. Francis Medical Group, 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.

Printed Name of Patient: _____ Date of Birth:_____

Signature of Patient/Guardian: _____ Date: _____

Printed Name of Guardian: _____ Relationship to Patient: _____

FOR INTERNAL USE ONLY

_____ _____

Name of Employee Signature of Employee

If applicable, reason patient's written acknowledgment could not be obtained:

☐ Patient was unable to sign.
☐ Patient refused to sign.
☐ Other: _____

PATIENT COMMUNICATION CONSENT

We may need to contact you regarding your medical care, appointments, test results, referrals, or any other reason. This is to acknowledge that you authorize St. Francis Medical Group to contact you and how you wish to be contacted (check all that apply):

	ORDER OF PREFERENCE:	OK TO LEAVE VOICEMAIL?	PHONE NUMBER:
HOME PHONE	❒1 ❒2 ❒3 ❒4 ❒5	❒YES ❒NO	
CELL PHONE	❒1 ❒2 ❒3 ❒4 ❒5	❒YES ❒NO	
WORK PHONE	❒1 ❒2 ❒3 ❒4 ❒5	❒YES ❒NO	
ALTERNATE PHONE	❒1 ❒2 ❒3 ❒4 ❒5	❒YES ❒NO	
PATIENT PORTAL & SECURE EMAIL	❒1 ❒2 ❒3 ❒4 ❒5	**EMAIL ADDRESS:**	
☐ None of the above			

PHI DISCLOSURE TO FAMILY MEMBERS

You may authorize us to contact a family member regarding your medical care or financial matters. This is to acknowledge that you authorize St. Francis Medical Group to disclose your PHI to the following individuals (check all that apply):

Name: ____ **Relationship to Patient:** ______________________
Telephone: (________)___________________ **Email:**____
Types of Information: ❒ Appointment Reminders ❒ Results (lab test, X-Ray, etc) ❒ Financial ❒ Other: ___________
Okay to contact via: ❒ Telephone ❒ Leave a Voice Mail ❒ Patient Portal & Secure Email ❒ Other: _____________

Name: ____ **Relationship to Patient:** ______________________
Telephone: (________)___________________ **Email:**____
Types of Information: ❒ Appointment Reminders ❒ Results (lab test, X-Ray, etc) ❒ Financial ❒ Other: ___________
Okay to contact via: ❒ Telephone ❒ Leave a Voice Mail ❒ Patient Portal & Secure Email ❒ Other: _____________

Name: ____ **Relationship to Patient:** ______________________
Telephone: (________)___________________ **Email:**____
Types of Information: ❒ Appointment Reminders ❒ Results (lab test, X-Ray, etc) ❒ Financial ❒ Other: ___________
Okay to contact via: ❒ Telephone ❒ Leave a Voice Mail ❒ Patient Portal & Secure Email ❒ Other: _____________

☐ **None of the above** **Signature:** ____