Notice of Privacy

I consent to allow Preventive Medicine to use or disclose my protected health information for:

Treatment. The coordination or management of health care and related services by other health care providers and to family members.

Name(s) of family members that can be informed about my health information in an emergency, etc: _____ Phone# _____

_____ Phone# _____

Payment. The activities undertaken by a health care provider or health plan to obtain or provide reimbursement.

Health Care Operations. The conducting of quality assessments and improvement activities; reviewing the activities related to health insurance contracts; medical reviews; legal services; auditing functions; and general administrative activities of Preventive Medicine.

I would like to receive a copy of this notice of privacy.

By signing below, I have been informed and agree to the above policies.

Name of patient (please print) _____

Signature _____ **Date** _____

Thank you kindly! We appreciate your choice for your health care needs!