DRAVES FAMILY PRACTICE

We are pleased to welcome you to our practice and thank you for choosing us. We are committed to providing quality patient care. The entire staff is at your service to answer your questions and serve your health care needs. Please let us know how we can best serve you by filling out the enclosed forms.

A federal regulation, known as the "HIPAA Privacy Rule," requires that we provide you a detailed notice in writing of our privacy practices. It also requires us to address any special needs you may have to assure your patient information is kept confidential.

May we call you and remind you of your appointment	**YES**	**NO**
May we leave a message on your answering machine if you are not available?	**YES**	**NO**
May we leave results of any diagnostic test on your answering machine if you are not available	**YES**	**NO**
May we call you at work with test results or other Health related issues: Work #__________________	**YES**	**NO**
Other than yourself, do you authorize our office to discuss your health information with another family member(s) or spouse	**YES**	**NO**

If so, whom _____________________ Relationship ____________________
_____________________ Relationship ____________________
_____________________ Relationship ____________________
_____________________ Relationship ____________________

<u>Consent for Purposes of Treatment, Payment and Healthcare Operation</u>

I consent to the use or disclosure of my protected health information by Draves Family Practice for the purposes of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Draves Family Practice

I have been informed by Draves Family Practice of their Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I also understand Draves Family Practice has the right to change their Notice of Privacy Practices and I may contact this organization at any time at the address given below to obtain a current copy of the Notice of Privacy Practices.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. I also

understand Draves Family Practice is not required to agree to my requested restrictions, but if they do agree then are bound to abide by such restrictions. I have the right to revoke this consent in writing at any time, except to the extent that Draves Family Practice has taken action relying on this consent.

Patient name: _______________________________

Signature____________________________________

Relationship to Patient:_____________________

Date: _______________________________________

Draves Family Practice
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