



NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Honor Community Health may use and disclose protected health information (PHI) about me to carry out Treatment, Payment, and Operations (TPO). I hereby acknowledge I have been offered or received Honor Community Health's Notice of Privacy Practices and that I may obtain a copy of the Notice of Privacy Practices at any time and that a copy of the Notice is posted in the Health Center.

Honor Community Health reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Honor Community Health at 461W. Huron, Pontiac, MI 48341-1601.

With my consent, Honor Community Health may call my home or other designated location using contact information that I provide and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others.

Honor Community Health may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements if they are marked "Personal and Confidential".

Honor Community Health may email or text me appointment reminders and patient statements. I have the right to request that Honor Community Health restrict how it uses or discloses my PHI to carry out the TPO. However, the Health Center is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I consent to the person(s) listed below having access to my entire Personal Health Information (PHI). I also authorize Honor Community Health to talk about my entire PHI to the person(s) listed below:

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

I give permission to the individual listed below to bring my children to their healthcare appointments and pick up medication from the pharmacy:

Name: _____ Relationship: _____ Phone #: _____

PRINT Name of Patient _____ Today's Date _____

SIGNATURE of Patient or Patient's Legal Guardian _____

Print Name of Patient's Legal Guardian (if applicable) _____