



NEW PERSPECTIVES HEALTH CARE, LLC

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Privacy Act Notice

I hereby give my consent for New Perspectives Health Care (NPHC) to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operation. (The Notice of Privacy Practices provided by NPHC describes such uses and disclosures more completely and is continually available in the waiting room at NPHC).

I have the right to review the Notice of Privacy Practices Prior to signing this consent. NPHC 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 Sandy Morrison or Sharon St. Angelo at NPHC.

With this consent, NPHC may call my home or other alternative location and leave a message on voice mail, email or in person in reference to any items that assist the practice in carry out Treatment, Payment and Health Care Operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, NPHC may mail to my home or other alternative location any items that assist the practice in carrying out Treatment, Payment and Health Care Operations, such as appointment reminder cards and patient statements.

With this consent, NPHC may email to my home or other alternative location any items that assist the practice in carrying out Treatment, Payment and Health Care Operations, such as appointment reminder cards and patient statements. I have the right to request that NPHC restrict how it uses or discloses my PHI to carry out Treatment Payment and Health Care Operations. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow NPHC to use and disclose my PHI to carry out treatment payment and health care operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, NPHC may decline to provide treatment to me.

Signed by: _____ (Signature of Patient or Legal Guardian)

Date: _____ Relationship to Patient: _____

Print Patient's Name: _____

Print Name of Legal Guardian, If Applicable: _____

(Parent or Guardian must be provided with a signed copy of this authorization form).