

**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 East Cooper Physicians 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 East Cooper Physicians any information obtained in the adjudication of any claim for services furnished to me by East Cooper Physicians.
- I acknowledge that East Cooper Physicians, 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 East Cooper Physicians 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	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	<input type="checkbox"/> YES <input type="checkbox"/> NO	
CELL PHONE	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	<input type="checkbox"/> YES <input type="checkbox"/> NO	
WORK PHONE	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	<input type="checkbox"/> YES <input type="checkbox"/> NO	
ALTERNATE PHONE	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	<input type="checkbox"/> YES <input type="checkbox"/> NO	
PATIENT PORTAL & SECURE EMAIL	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	<b>EMAIL ADDRESS:</b>	
<input type="checkbox"/> 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 East Cooper Physicians 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:** \_\_\_\_\_