FORM 111 - R170621

Notice of Privacy Practices Acknowledgement

I understand that the Salem Pediatric Clinic will use and disclose health information about this patient. I understand that health information may include information created or received by the clinic either written, electronic or spoken words. The health information may include health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions and similar health related information.

I understand and agree that the clinic may use and disclose this health information in order to:

- Make decisions about and plan for care and treatment.
- Refer to, consult with, coordinate and manage care and treatment with other health care providers.
- Determine eligibility for health plan or insurance coverage; submit bills or claims and other related information to insurance companies or others who are responsible to pay for a portion of the health care.
- Perform various office, administrative and business functions that support the physician's efforts to provide or arrange the patient with healthcare and be reimbursed for that care.
- These guidelines are disclosures for treatment, payment and healthcare operations.

I understand that I have the right to receive and review a written description of how the clinic will handle health information about this patient. This written description is known as a **Notice of Privacy Practices**.

I understand that the **Notice of Privacy Practices** may be revised and that I am entitled to receive a copy of any revisions. I also understand that a copy of the most current version will be available at the front desk.

I understand that I have the right to ask that some or all of this patient's health information not be used or disclosed in the manner described in the **Notice of Privacy Practices**. I understand that the clinic is not required by law to agree to such requests.

BY SIGNING BELOW, I AGREE THAT I HAVE REVIEWED AND UNDERSTAND THE INFORMATION ABOVE AND THAT I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES.

Signed by _____ **Date** _____

Print Name _____ **Relationship to patient** _____

Patient Name _____ **Patient date of birth** _____

Salem Pediatric Clinic

2478 13th Street SE
Salem, Oregon 97302
503-362-2481 · Phone
503-371-7803 · Fax
SalemPediatricClinic.com