Oregon Medical Group Notice of Privacy Practices (NPP) Acknowledgment

I understand that as a part of my health care, Oregon Medical Group must use and disclose health information about me.

I understand that my health information may include information both created and received by Oregon Medical Group, may be in the form of written or electronic records, spoken words, or other media and may include information that can be used to identify me and that relates to my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

Patient Label

I understand that Oregon Medical Group has the right to use and disclose my health information in order to:

- make decisions about and plan for my health and treatment;
- refer to, consult with, coordinate among, and manage my care and treatment with other health care providers;
- determine my eligibility for health plan or insurance coverage, submit bills, claims, and other related information to insurance companies, guarantors, or others who may be responsible to pay for some or all of my health care; and
- operate our business.

I understand I have the right to receive and review a written notice of how Oregon Medical Group will handle health information about me. This written notice, known as a Notice of Privacy Practices (NPP), describes the uses and disclosures of health information, the health information privacy practices followed by Oregon Medical Group, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of Oregon Medical Group's Notice of Privacy Practices can be seen posted in Oregon Medical Group clinical sites and on Oregon Medical Group's web site: **www.OregonMedicalGroup.com**.

I understand that I have the right to ask to restrict uses or disclosures of my health information for treatment, payment, or business health care operations, or to family members or others involved in my health care or payment for my health care. I understand that Oregon Medical Group is not required to agree to the restrictions I may request, except for certain disclosures to health plans where I, or another person on my behalf, has paid for the service in full.

I acknowledge that I have received and/or have been offered a copy of Oregon Medical Group's Notice of Privacy Practices.

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Signature of Patient or Legal Guardian/Representative **Date**

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Printed Patient Name **Patient's Date of Birth**