Place Patient Label Here

NPP Acknowledgment

I understand that as part of my healthcare, **OREGON MEDICAL GROUP** will 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 or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that Oregon Medical Group may **use and disclose** my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how Oregon Medical Group will handle health information about me. This written description is known as a **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of 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 will be posted in the waiting/reception area and is available on the group's web site www.oregonmedicalgroup.com.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that Oregon Medical Group is not required to agree to the restrictions I may request.

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

______________________________	__________________
Signature of Patient or Legal Guardian	Date
______________________________	__________________
Print Patient Name	Patient's Date of Birth