Notice of Privacy Practices Acknowledgement

Honor Community Health may use and disclose protected health information (PHI) about me to carry out Treatment, Payment, and Operations (TPO). Please refer to Honor Community Health's Notice of Privacy Practices posted in the clinic for a more complete description of such uses and disclosures.

Honor Community Health observes 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 Honor Community Health at 461 W. Huron, Pontiac, MI 48341-1601.

With my consent, Honor Community Health may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others.

Honor Community Health may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential".

Honor Community Health may email or text me appointment reminders and patient statements. I have the right to request that Honor Community Health restrict how it uses or discloses my PHI to carry out the TPO. However, the center 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 Honor Community Health's use and disclosure of my PHI to carry out TPO. I understand that I may revoke my consent in writing to the extent that the practice has already made disclosures in reliance to my prior consent. If I do sign the consent, Honor Community Health may decline to provide treatment to me.

I consent to the person(s) listed below having access to my entire Personal Health Information (PHI). I also authorize Honor Community Health to talk about my entire PHI to the person(s) listed below:

Name: ______________________________ Relationship: _____________________________ Phone #:_________________

Name: ______________________________ Relationship: _____________________________ Phone #:_________________

I give permission to the individual listed below to bring my children to their healthcare appointments and pick-up medication from the pharmacy:

Name: ______________________________ Relationship: _____________________________ Phone #:_________________

X____ _______________

Signature of Patient or Patient's Legal Guardian (if applicable) Date

____ ____

Print Patient's Name Print Name of Patient's Legal Guardian (if applicable)