Desert Peaks Health Care

NOTICE OF PRIVACY PRACTICES AGREEMENT

By signing, I agree that I have reviewed and understand the information below and that I am entitled to have a copy of Desert Peaks Health Care's Notice of Privacy Practices if I so choose by informing the office staff.

My health information may be created or received by Desert Peaks Health Care and may be in the form of written or electronic records or spoken words. My health record may also include information of my health history, health status, test results, diagnoses, treatments, procedures, prescriptions and similar types of health related information.

I understand that I have the right to receive and review a written description of how Desert Peaks Health care will handle my health information. This written description is known as the 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 Desert Peaks Health Care and my right 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 summary of the most current version of Desert Peak Health Care's Notice of Privacy Practices in effect will be posted in the waiting/reception area.

Patient's Printed Name ____

Patient's Signature ____ Date _________________________

Desert Peaks Health Care

SPECIAL PERMISSION REQUEST

By initialing I give my permission for Desert Peaks Health Care to leave messages on my home or mobile number:

regarding appointments ________________(initial)

regarding test results _______________(initial)

I give my permission to have messages regarding treatment, billing and/or appointment status left with my spouse, partner and/or care giver as indicated below:

☐ Spouse Printed Spouse Name: ____________________________________ Phone #: _________________________

☐ Partner Printed Partner Name: ___________________________________ Phone #: _________________________

☐ Other Printed Name: ________________________________ Relationship:______________________________

Phone #: _________________________

Patient's Signature ____ Date _________________________

This release will be revoked only by written permission. I understand that I must send a written request to Desert Peaks Health Care in order to revoke this release.

Patient's Signature ____ Date _________________________

Notice of Privacy Practices Agreement & Special Permissions Request Reviewed: initials/date_________________

initials/date__________________