Northwest PRIMARY CARE

Acknowledgment and Consent

I understand that Northwest Primary Care will use and disclose health information about me. I understand that my health information may include information both created and received by Northwest Primary Care, 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 Northwest Primary Care 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 healthcare
- perform various office, administrative and business function that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective healthcare
- to researchers, provided that the research has been approved by an Institutional Review Board and/or a Privacy Board, and the research protocols have been approved to ensure your privacy. We may disclose health care information about you to people preparing to conduct a research project.

I also understand that I have the right to receive and review a written description of how Northwest Primary Care 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 Northwest Primary Care, 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 This Practice's Notice of Privacy Practices in effect will be posted in waiting/reception area and our website at www.nwpc.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 Northwest Primary Care 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.

Patient Name (Print) DOB

Patient Name (Signature) Date

Patient or Patient Representative Signature Date

Description of Representative's Authority

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