ACKNOWLEDGEMENT AND CONSENT

I understand that Cedar Creek Internal Medicine (referred to below as "This Practice") will use and disclose *Health Information* about me.

I understand that my Health Information may include information both created and received by The Practice, may be in the form of written or electronic records or the spoken word and may include information about my health history, health status, symptoms, examinations, test result, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that This Practice 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 with other healthcare providers for my care and treatment.
- Determine my eligibility for health plan or insurance coverage and to 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 functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost effective, healthcare.

I also understand that I have the right to receive and review a written description of how This Practice will handle health information about me. This written description is known as a *Notice of Privacy Practices.* This describes the uses and disclosures of health information and the information followed by all employees, staff, and other office personnel of This Practice. It also explains 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* upon my request. I also understand a copy or a summary of the most current version if This *Practice's Notice of Privacy Practices* in effect will be posted in a waiting/reception area.

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 This Practice is not required by law to agree to such requests.

By signing below, I agree that I have read and understand the information above and that I have seen a copy of the *Notice of Privacy Practices.*

______________________________ ______________________________

Patient Signature Date

______________________________ ______________________________

Patient Representative Date

Description of Representative's Authority:

Revised 08/08/2008