PEACHWOOD MEDICAL GROUP CLOVIS, INC

ACKNOWLEDGMENT OF RECEIPT

Federal law requires that we seek your acknowledgment of receipt of this Notice of Privacy Practices. Please sign below.

I acknowledge that I have received this Notice of Privacy Practices with an effective date of November 1, 2011, and understand that if I have any questions regarding this Notice, I may contact the Privacy Officer.

I hereby provide my consent for Peachwood Medical Group to obtain my Rx History using the SureScripts network. I understand that this inquiry will provide my physician with an accounting of my medication history reported by Pharmacy Benefit Managers and retail pharmacies. I also understand that SureScripts has certified that Rx History Capture follows strict security protocols to align with HIPAA requirements and respect patient privacy.

Signature: ______________________________ Date: __________

Printed Name: ______________________________ Date: __________

Signature of Parent/Guardian: ____________________ Date: __________

AUTHORIZATION TO USE & DISCLOSE HEALTH INFORMATION

I authorize Peachwood Medical Group to use and disclose a copy of the specific health and medical information described below regarding:

Name of Patient: ____

Consisting of: ____

Name of Recipient: ____

For the Purpose of: ____

If we are requesting this Authorization from you for our own use and disclosure, or to allow another healthcare provider or health plan to disclose information to us:

- We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;
- You may inspect a copy of the protected health information to be used or disclosed;
- You may refuse to sign this Authorization; and
- We must provide you with a copy of the signed authorization.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

By: ____ Date: ____________

Or By: ____ Date: ____________

(Patient's Representative and description of authority)