



**NOTICE and ACKNOWLEDGEMENT OF OUR PRIVACY PRACTICES**

While **307Health, P.C. (307Health)** does not file insurance claims or accept payment from third-party payers, we still follow generally accepted industry privacy standards as outlined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Under HIPAA’s standards your personal information may be used to:

- Provide and coordinate your treatment among a number of health providers who may be involved in your treatment directly or indirectly.
- Conduct normal healthcare operations such as quality assessment and improvement activities.
- Obtain payment from third-party payers for your healthcare services. [Not applicable to **307Health**]

This document informs you of **307Health’s** Notice of Privacy Practices. You may request a copy of this Notice for your own use. **307Health** reserves the right to change the Notice of Privacy Practices and you may contact this office to obtain a current copy of the Notice of Privacy Practices.

You may request in writing that **307Health** restrict how your private information is used or disclosed to carry out treatment, payment, or health care operations.

Requested Restrictions:

You have the right to receive treatment from **307Health** even if you choose to not sign this agreement.

You authorize **307Health** to communicate your Protected Health Information (PHI) via these non-secure methods – Please check all that apply:

- 307Health** may leave a detailed message on voicemail at my home # (\_\_\_\_)\_\_\_\_\_.
- 307Health** may leave a detailed message on voicemail at my cell # (\_\_\_\_)\_\_\_\_\_.
- 307Health** may leave a detailed text message at my cell # (\_\_\_\_)\_\_\_\_\_.
- 307Health** may leave a detailed email message at this email address \_\_\_\_\_.

**Emergency Contact(s)** – Two emergency contacts are requested per member.

Name/Relation: \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_.

Name/Relation: \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_.

**307Health** may speak about my medical condition with my emergency contacts ....

**Including** /  **Excluding** information related to mental/behavioral health, substance abuse, sexually transmitted disease, HIV status and reproductive medicine.

**307Health** may also speak about my medical condition with the following persons:

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the instructions above will be honored until revoked by me in writing. I understand that if I initiate a non-secure communication with **307Health** by any manner not previously authorized above, I thereby authorize **307Health** to continue communicating with me regarding my PHI via this non-secure method. It is my responsibility to notify **307Health** should any of my contact information change.

\_\_\_\_\_/\_\_\_\_\_  
Signature Today’s Date

\_\_\_\_\_/\_\_\_\_\_  
Member Name Date of Birth

\_\_\_\_\_  
Representative Name (if parent, guardian or POA)

\_\_\_\_\_  
Relation to Patient

**For administrative use only:**

We are unable to obtain the patient’s written acknowledgement of our Notice of Privacy Practices due to the following reasons:

- Patient declined to sign
- Emergency situation
- Communication barrier(s)
- Other: \_\_\_\_\_