SLMC Account #_____

Notice of Privacy Practices
Acknowledgement & Authorization Form

Patient Name: DOB:

Notice of Privacy Practices (NPP)

The Notice of Privacy Practices (NPP) explains how St Louis Medical Clinic (SLMC) may use and share your protected health information (PHI). It also describes your rights with respect to your PHI.

- SLMC will use and share your PHI to treat you and to bill for the services we provide.
- SLMC will use and share your PHI in the general course of operating our business.
- SLMC will use and share your PHI as required and allowed by law.

Pharmacy/Medication Consent

SLMC has the ability to obtain a list of your medications electronically when submitting your prescription to your pharmacy. However, we require your consent in order to obtain this information:

Please circle one below: I give my permission for my physician to obtain my prescription list from the pharmacy.
↳ YES / NO

Authorized Individuals

I give authorization to the doctors and staff of St Louis Medical Clinic to discuss my protected health information (PHI) and financial information with the following people.
The individual(s) named below will also be considered emergency contact(s) unless you specify otherwise.
If SLMC has a Durable Power of Attorney on file for a patient, PHI will be released to the authorized person.

	NAME	RELATIONSHIP
1		
2		
3		

- I understand that the NPP is available on the SLMC website (www.stlmedclinic.com) and at my physician's office.
- I acknowledge I was offered a copy of the SLMC Notice of Privacy Practices (NPP).
- I understand that it is my responsibility to inform SLMC of any desired changes to the list of authorized individuals.
- I hereby give permission to SLMC to: leave voice mail messages containing PHI and account information at my home or on my cell phone; to fax or e-mail PHI to me at my request; or contact me at my place of employment if I have provided a work phone number.

Signature of Patient or Representative Print Name Date