U.P. North Family Medicine DPC, PLLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received the U.P. North Family Medicine, DPC, PLLC, Notice of Privacy Practices effective November 1, 2024, and I have been provided an opportunity to review it.

In addition, I acknowledge that should I communicate with U.P. North Family Medicine through email, text, instant messaging, social media, or other non-telephone methods of communication, these are not secure mediums for sending or receiving sensitive personal health information. I acknowledge and understand that email, text, instant messaging, and social media are not ideal for urgent or time-sensitive communications. In the event the communication is time sensitive, I must communicate with U.P. North Family Medicine, DPC, PLLC by telephone. In the event of an emergency, I agree to call 911 or proceed to the nearest emergency department.

_____

Printed Name of Patient or Legal Guardian

_____ _____

Signature Date

Other than me, the following individuals may have full disclosure to my personal health information:

Full Name:_____ Relation:_____ Phone: _____

Full Name:_____ Relation:_____ Phone: _____

Full Name:_____ Relation:_____ Phone: _____

Full Name:_____ Relation:_____ Phone: _____

Please note: In case of emergency, or if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will use our professional judgment to make decisions in your best interest regarding medications, medical supplies, or other medical information for you. We may also notify such people of your location or condition.