Receipt of Notice of Privacy Practices and Consent

- I acknowledge that I have received the Premier Medical Group, P.C. ("Premier") Notice of Privacy Practices.
- I consent to uses and disclosures described in the section titled "How We May Use and Disclose Your PHI (without an authorization)", including but not limited to sharing of information through Health Information Exchanges (HIEs) and participation in the Patient Record Sharing program. I understand that other uses and disclosures will require a separately signed authorization.

_____
PRINTED Patient Name

_____ _____
Patient or Personal Representative Signature Date

If this form is signed by a Personal Representative, please describe the Personal Representative's relationship to the patient:

_____

For Premier use only:

If not signed, reason why signature was not obtained:_____

_____
PRINTED Staff Person Name

_____ _____
Staff Person Signature Date