Mill Creek Family Practice, PLLC

Notice of Acknowledgement of Privacy Practices and Consent to Discuss Medical Care

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information. This is available at the front desk as well as on our website www.millcreekfamilypractice.org. You may see your record or get more information about it by contacting Glynis Thakur, Privacy Officer, at (425) 338-4000.

CONSENT TO DISCUSS MEDICAL CARE

Mill Creek Family Practice, PLLC may discuss my medical information with the following individuals. We may also contact those listed in case of a medical emergency. PLEASE PRINT ALL NAMES LISTED BELOW. PLEASE **DO NOT LIST PHYSICIANS.**

NAME	RELATIONSHIP TO PATIENT	PHONE NUMBER
EXAMPLE: Jane Doe	Spouse	425-555-1234

VOICEMAIL – CONSENT TO LEAVE DETAILED MEDICAL INFORMATION

I give permission for Mill Creek Family Practice, PLLC to leave detailed medical information at my telephone number(s) below:

☐ ( ) _____ ☐ ( ) _____

OR

☐ **I DO NOT WISH TO HAVE DETAILED MEDICAL INFORMATION LEFT ON VOICEMAIL**

I have reviewed a copy of the Notice of Privacy Practices which provides information about how my health information may be used and disclosed. I have read and understand the Financial Policy of Mill Creek Family Practice, PLLC. I assign payment from my insurance directly to Mill Creek Family Practice, PLLC. I understand that I am financially responsible to MCFP for the charges not paid by insurance and that those charges are due within 30 days of receipt of billing statement. I have authorized MCFP to discuss my medical information with the individuals listed above.

I consent to the plan of care proposed by the providers in this clinic. I understand that I, or my authorized representative, have the right to decide whether to accept or refuse this plan of care. I will ask for any information I want to have about my medical care and will make my wishes known. I understand that MCFP participates in the training of physicians and other healthcare providers and I consent to their involvement. I understand that the practice of medicine is not an exact science and acknowledge that no guarantees have been made to me regarding the likelihood of success or outcomes of any examination, treatment, diagnosis or test performed by MCFP.

PATIENT NAME: _____ DATE OF BIRTH: _____

SIGNATURE: _____ TODAY'S DATE: _____

Printed Name (If signed on behalf of patient): _____ *Relationship:* _____