Acknowledgement of Receipt of Notice

Dublin Primary Care
2685 Dublin Blvd
Colorado Springs, CO 80918
719-592-9890
Eric Speer, Administrator

Dublin Primary Care endorses, supports, and participates in electronic Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. HIE provides us with a way to securely and efficiently share patients' clinical information electronically with other physicians and health care providers that participate in the HIE network. Using HIE helps your health care providers to more effectively share information and provide you with better care. The HIE also enables emergency medical personnel and other providers who are treating you to have immediate access to your medical data that may be critical for your care. Making your health information available to your health care providers through the HIE can also help reduce your costs by eliminating unnecessary duplication of tests and procedures. However, you may choose to opt-out of participation in the CORHIO, HIE, or cancel an opt-out choice, at any time.
I hereby acknowledge that I received a copy of this medical practice's 2013 HIPAA Omnibus Final Rule Notice of Privacy Practices.

Yes No (circle one) I would like to receive a copy of any amended Notice of Privacy Practices.

Signed:_____Date: _____

Print Name:_____Telephone: _____

If not signed by the patient, please indicate:
Relationship:

- Parent or guardian of minor patient
- Guardian or conservator of patient
- Beneficiary or personal representative of deceased patient

Name of Patient:_____Date of Birth:_____

PATIENTS SIGNATURE ON FILE FOR MEDICAL CLAIMS

I request that payment of authorized health insurance benefits be made on my behalf to : **Dublin Primary Care** for any services furnished to me by this provider.
Dublin Primary Care will submit your insurance claim for you to your insurance company in effect at time of service. After your insurance carrier processes your claim, Dublin Primary Care will send a statement with any unpaid balance.

Signed: _____Date: _____

Relationship to Patient:_____

For Office Use Only:
Signed Form Received by: _____
Acknowledgement refused:
Efforts to obtain:_____