RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT FORM AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

DoctorsCare

Patient Giving Consent:

Name: ____

Address: ____

Telephone: ____

Social Security Number: ____

Patient: Please read the following statements carefully:

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, healthcare operations, and other uses disclosed in our "Notice of Privacy Practices".

Notice of Privacy Practices:

You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, and other uses and disclosures we may make of your protected health information, and other important matters about your protected health information. A copy of our Notice is provided here with. We encourage you to read it carefully and completely before signing the Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice which will contain the changes.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Administrator listed above.

I acknowledge receipt of DoctorsCare's "Notice of Privacy Practices" and have had the opportunity to read and consider the contents of this Consent form and Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

Signature of Patient: ___________________________________ Date: _________________________________

Signature of Guardian: ___________________________________ Date: _________________________________

By signing this consent for you are agreeing that DoctorsCare can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

Understanding all of the above, I hereby provide informed consent to DoctorsCare to enroll me in the ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Signature: ___________________________________ Date: _________________________________

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Name: _______________________________________ Relation to Patient: ______________________

Rev. 01/06/2012