HICKORY MEDICAL

DIRECT PRIMARY CARE, LLC

Name: _____ Date of Birth: _____

Acknowledgement of receipt of Notice of Privacy Practices

_____ Initials

I have received a copy of the practice's notice of Privacy Practices for Protected Health Information (PHI). A copy of the notice is also accessible at http://www.hickorydpc.com/privacy

Prescription History Consent

_____ Initials

I understand that performing a medication reconciliation in order to prevent adverse drug interactions and overdose is a critical component of my care. I authorize Hickory Medical Direct Primary Care, LLC to query and review my medication fill history including medication, dose, form, strength, prescribing provider, and pharmacy.

Sending Unencrypted Protected Health Information by Email or Text

_____ Initials

I understand that communication by email and text can lead to more efficient communication and can benefit my care. I understand that precautions are taken to protect my information, but recognize that email and text messaging are not a completely secure means of communication. I authorize Hickory Medical Direct Primary Care, LLC to exchange information that may include Protected Health Information by unencrypted email and text.

Communication Preferences regarding Protected Health Information

_____ Initials

I understand that it may be helpful for my care if the physicians and staff of Hickory Medical Direct Primary Care, LLC discuss my Protected Health Information (PHI) with others. I give permission to share my PHI with the following named individuals:

Spouse/Significant other: _____

Parent: _____

Child/Grandchild: _____

Caregiver: _____

Other: _____

It is OK to leave a message: ☐ Answering machine ☐ Cell phone ☐ At work

_____ _____

Patient/Representative signature Date