Patient Name: _____ **Date of Birth:**_____

Communicating with Family and Friends

- We may communicate your information with others who are involved in your care.
- We will only communicate when we believe that this would be helpful to you.
- We are not able to keep any earlier requests made on the "Permission to Communicate with Family and Friends" form that you may have completed in the past.

Sharing through *Care Everywhere*

Care Everywhere is part of the new electronic medical record (EMR) we are using. It lets your doctors, nurses and non-Novant healthcare providers share information about you. If you get treated in other places, this lets those taking care of you get your health information quickly.

If you do not want your health information shared through *Care Everywhere*, you may ask that it NOT be available through *Care Everywhere*. The Practice Manager of your doctor's office or the Health Information Management department at the facility where you are being treated can help you with this. If you decide not to allow your health information to be shared through *Care Everywhere*, other healthcare providers will not be able to access health information about you through our EMR.

HIPAA – Notice of Privacy Practices

- I have been provided with a copy of Novant Health's **Joint Notice of Privacy Practices**.
- I know that the Notice may be changed at any time.
- I may get a new copy of the Notice on Novant Health's website at www.novanthealth.org; by writing to the Privacy Official, Novant Health Privacy Office, P.O.Box 33549, Charlotte, NC 28233; or by asking for a copy at any Novant Health facility.

_____

Patient's Signature Date/Time

_____ _____

Signature of Authorized Person Date/Time Relationship to Patient

For staff use only:

☐ *Patient refused to sign. Patient was informed that signing merely acknowledges that the Notice has been made available to the patient; or* ☐ *Patient was initially treated for an emergency condition. The Notice was made available to the patient either after stabilization or upon transfer.*

*Signature of Staff:*_____ *Date:*_____ *Time:*_____

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

☐ Interpreter Accepted _____ ☐ Interpreter Refused

(Name/Number of Person/Services Chosen/Used)

Name / MR # / Label