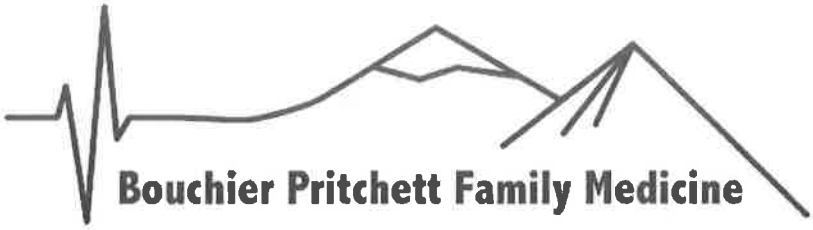


PATIENT INFORMATION

Patient Name: _____ Marital Status: _____

Date of Birth: _____ Sex: _____

Street Address: _____

Mailing Address: _____

Primary Phone: _____ Cell Phone: _____

Work Phone: _____

Please select to leave limited or detailed voicemail on the following:

Primary: L / D Cell Phone: L / D Work: L / D

Preferred Lab: _____

Preferred Imaging Center: _____

Pharmacy Name: _____

Occasionally we will communicate with patients regarding flu clinic's or general updates. Please help us to communicate in the best way possible.

Email _____ __Opt In __Opt Out

Text Message (____) _____ __Opt In __Opt Out

I am interested in learning about the Patient Portal. Y / N

EMERGENCY CONTACTS:

Emergency Contact Name: _____ Phone Number: _____

RESPONSIBLE PARTY

Name of Person Responsible for Bill: _____ Relation to Patient: _____

Address: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____

INSURANCE INFORMATION

Primary Insurance: _____ Phone Number: _____

Claims Address: _____

Subscriber Name: _____ Date of Birth: _____

Subscriber ID: _____ Group Number: _____

Secondary Insurance: _____ Phone Number: _____

Claims Address: _____

Subscriber Name: _____ Date of Birth: _____

Subscriber ID: _____ Group Number: _____

Bouchier Pritchett Family Medicine

280 Sierra College Drive, Ste 207, Grass Valley, Ca 95945 p.530-477-7390 f. 530-477-7389

Authorization to Release Medical Records

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

Previous Name: _____ **Social Security#:** _____

Phone Number: h._____ **c .**_____

Address: _____ **City:**_____ **State:**_____ **Zip:**_____

I hereby authorize: (Provider or Group)_____

(phone) _____ to release medical records and data on the above-named patient to:

Name: **Bouchier Pritchett Family Medicine** Phone:**530-477-7390** Fax**: 530-477-7389**

Address: **280 Sierra College Dr, Ste 207, Grass Valley, Ca 95945**

This request and authorization applies to:

- ☐ All records
- ☐ All records between the dates of _____and _____
- ☐ Records pertaining to_____

Purpose of disclosing information: _____

This notice will expire 1 (one) year from signed date unless otherwise noted. Expiration date: _____

I authorize the release of specific/or complete medical records to the person or physician named above. This includes any and all information related to the examination, diagnosis and treatment rendered to me. I acknowledge that the information being released may include material related to MENTAL HEALTH CONDITIONS, DRUG AND/OR ALCOHOL USE and that this information is protected by Federal law. My signature below authorizes the release of this information.

Patient/Guardian Signature:_____ **Date:**_____

Specific Authorization: I acknowledge the information being released may include material related to the diagnosis and/or treatment of HIV (AIDS VIRUS). My signature below authorizes the release of this information.

Patient/Guardian Signature:_____ **Date:**_____

Internal use only:

Completed By: _____

Date Records Mailed/Picked-up: _____

Bouchier Pritchett Family Medicine

280 Sierra College Drive, Ste 207, Grass Valley, Ca 95945 p.530-477-7390 f. 530-477-7389

Authorization to Release Protected Health Information (PHI) to Family Members or Designated Individuals

HIPAA Laws prevent us from discussing or disclosing your protected health information to family members, friends or other designated individuals unless you provide Bouchier & Pritchett Family Practice with authorization to release this information. We are required to have a completed authorization form on file prior to releasing your protected health information. Should a change be required, it is the patients' responsibility to notify the office of such changes. The most recently dated form will be considered current and will negate any previous versions.

I, _____ Date of birth_____
authorize Bouchier & Pritchett Family Practice to disclose my protected health information to the individual(s) listed below:

Name	Phone#	Relationship

Health information to be disclosed (Check all that applies):

☐ **My Complete Health Record (including but not limited to diagnoses, lab tests, prognosis, treatment and billing for all conditions) or**

My complete health record, as above, **with the exception of the follow information:** (Check as appropriate)

- ☐ Mental Health Records
- ☐ Communicable diseases (including HIV & AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ Other (please specify):_____

The health information may be used to enable the persons I authorize to know and understand my condition and my treatment options, for treatment or consultation, for claims payment purposes or related reasons. I understand that this Authorization is voluntary and I may revoke my authorization in writing at any time.

Signature: _____ Date:_____

Printed Name of Legally Authorized Representative (if applicable):_____

Relationship: ☐ Parent or legal guardian ☐ Power of Attorney ☐ Other:_____

Bouchier & Pritchett Family Medicine

Financial Agreement and Office Policies

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

Patients Information Responsibilities:

- Change of Information: It is the patient's responsibility to inform the office of any address, phone number or insurance changes prior to appointment. Failure to do so may cause your account to be in delinquent status.
- Proof of insurance: All patients must complete our patient information form before seeing the provider. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the balance of a claim.

Patient (Guardian) Initial: _____

Insurance Billing & Collections Policy:

- Insurance. We participate in most insurance plans, including Medicare. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required at time of visit until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
- Cash Pay. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you do not have insurance, payment in full is required at the end of your visit. Failure to stay current on your account may require us to refer your account to a collections agency and will result in dismissal from our practice.
- Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company.
- Non-covered services. Please be aware that some – and perhaps all – of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. In this event you will be responsible for payment.
- Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
- Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice with notification via certified mail.
- Returned Payment. All returned payments will incur a $25 service fee in addition to returned payment amount. All returned payments must be paid in full prior to future appointments.

Patient (Guardian) Initial: _____

No Show, Cancelled and Late Appointment Policy:

- Missed appointments. We are a busy practice and respect all of our patient's time. To help stay on time we adhere to a strict 5 minute reschedule policy. We also require 24 hours' notice for any cancelations or reschedules. Failure to do so will result in your appointment being considered a "no-show" and a $50 fee billed directly to you. Consistent tardiness and or three (3) no show's will result in discharge from our practice, notified via certified mail.

Patient (Guardian) Initial: _____

Our practice is committed to providing the best treatment to all our patients. Thank you for understanding our policy so we may be able to serve every patient in the best possible way.

I have read and understand the policies and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party Date

_____ _____

Patient Name Date of Birth

Health History

Today's Date _____

Name_____ Age_____ Birthdate_____ Last Physical Exam_____

Reason for today's visit: _____

SYMPTOMS: check (√) symptoms you currently have or have had in the past year

GENERAL:

☐ Chills
☐ Depression
☐ Dizziness
☐ Fainting
☐ Forgetfulness
☐ Headaches
☐ Loss of sleep
☐ Loss of weight
☐ Nervousness
☐ Numbness
☐ Sweats

MUSCLE/JOINT/BONE:
Pain, weakness and/ or numbness in:

☐ Arms ☐ Hips
☐ Back ☐ Shoulders
☐ Feet ☐ Neck
☐ Hands ☐ Legs

GENITO-UNINARY:

☐ Blood in urine
☐ Frequent urination
☐ Lack of bladder control
☐ Painful urination

GASTROINTESTINAL:

☐ Appetite poor
☐ Bloating
☐ Bowel changes
☐ Constipation
☐ Diarrhea
☐ Excessive hunger
☐ Excessive thirst
☐ Gas
☐ Hemorrhoids
☐ Indigestion
☐ Nausea
☐ Rectal bleeding
☐ Stomach Pain
☐ Vomiting
☐ Vomiting blood

CARDIOVASCULAR:

☐ Chest pain
☐ High blood pressure
☐ Irregular heart beat
☐ Low blood pressure
☐ Poor circulation
☐ Rapid heart beat
☐ Swelling of ankles
☐ Varicose vein

EYE,EAR,NOSE,THROAT:

☐ Bleeding gums
☐ Blurred vision
☐ Crossed eyes
☐ Difficulty swallowing
☐ Double vision
☐ Earache
☐ Ear discharge
☐ Hay fever
☐ Hoarseness
☐ Loss of hearing
☐ Nosebleeds
☐ Persistent cough
☐ Ringing in ears
☐ Sinus problems
☐ Vision-Flashes
☐ Vision-Halos

SKIN:

☐ Bruise easily
☐ Hives
☐ Itching
☐ Change in moles
☐ Rash
☐ Scars
☐ Sore that won't heal

MEN Only:

☐ Breast lump
☐ Erection difficulties
☐ Lump in testicles
☐ Penis discharge
☐ Sore on penis
☐ Other _____
_____
_____

WOMEN Only:

☐ Abnormal Pap Smear
☐ Bleeding between periods
☐ Breast lump
☐ Extreme menstrual pain
☐ Hot flashes
☐ Nipple discharge
☐ Painful Intercourse
☐ Vaginal discharge
☐ Other_____
Date of last period_____
Date of last PAP_____
Have you had a mammogram?
☐ NO ☐YES: Date_____
Are you pregnant? _____

Health History

CONDITIONS: check (√) conditions you currently have or have had in the past year

☐ Aids	☐ Chemical dependency	☐ High cholesterol	☐ Prostate problem
☐ Alcoholism	☐ Chicken pox	☐ HIV positive	☐ Psychiatric care
☐ Anemia	☐ Diabetes	☐ Kidney disease	☐ Rheumatic fever
☐ Anorexia	☐ Emphysema	☐ Liver disease	☐ Scarlet fever
☐ Appendicitis	☐ Epilepsy	☐ Measles	☐ Stroke
☐ Arthritis	☐ Glaucoma	☐ Migraine headaches	☐ Suicide attempt
☐ Asthma	☐ Goiter	☐ Miscarriage	☐ Thyroid problem
☐ Bleeding disorder	☐ Gonorrhea	☐ Mononucleosis	☐ Tonsillitis
☐ Breast lump	☐ Gout	☐ Multiple Sclerosis	☐ Tuberculosis
☐ Bronchitis	☐ Heart disease	☐ Mumps	☐ Typhoid fever
☐ Bulimia	☐ Hepatitis	☐ Pacemaker	☐ Ulcers
☐ Cancer	☐ Hernia	☐ Pneumonia	☐ Vaginal infections
☐ Cataracts	☐ Herpes	☐ Polio	☐ Venereal disease

FAMILY HISTORY: check (√) any that apply

Mother: Age_____

☐ Diabetes
☐ Hypertension
☐ Heart Disease
☐ Stroke
☐ Mental Illness
☐ Cancer: _____
☐ Asthma
☐ Other: _____

Father: Age_____

☐ Diabetes
☐ Hypertension
☐ Heart Disease
☐ Stroke
☐ Mental Illness
☐ Cancer: _____
☐ Asthma
☐ Other: _____

Siblings:

Number of brothers: _____, healthy? ☐ YES ☐ NO
If no why: _____
Number of sisters: _____, healthy? ☐ YES ☐ NO
If no why: _____

Children:

Number of children, if any: _____, healthy?
☐ YES ☐ NO: why_____

MEDICATIONS: List medications you are currently taking, please include dose, directions and amount remaining.

_____
_____
_____
_____
_____

Pharmacy: _____Location:_____

Which lab do you use to get blood drawn? _____

SURGICAL HISTORY: Include date and procedure

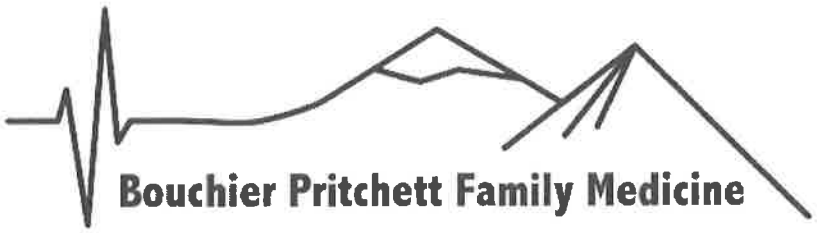
_____
_____

Medication allergies:_____

_____

Hospitalizations: Include date and reason.

_____
_____



280 Sierra College Dr, Grass Valley, Ca 95945

Acknowledgement of Receipt of Notice of Privacy Practices

I have received and understand Bouchier-Pritchett Family Medicine Notice of Privacy Practices. The Notice provides, in detail, the uses and disclosures of my protected health information that may be made by BPFM and its affiliated physicians and health care providers, my individual rights, how I may exercise these rights, and BPFM's legal duties with respect to my medical information. I understand that BPFM reserves the right to change the terms of its Notice of Privacy Practices and to make changes regarding all protected health information resident at or controlled by BPFM.

With my consent, Bouchier Pritchett Family Medicine may mail to my home or other designated location any items that assist in my treatment, payment and healthcare operations, such as appointment reminders and patient billing statements.

Patient Printed Name: _____ Date of Birth: _____

Patient (Guardian) Signature: _____ Date: _____

Bouchier & Pritchett Family Medicine

280 Sierra College Dr, Grass Valley, Ca 95945

Notice of privacy practices

Effective date: July 1st, 2017

Bouchier & Pritchett Family Practice at 280 Sierra College Dr, Grass Valley, Ca 95945

Notice of Privacy Practices

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). **This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your individually identifiable health information.**

Please review this notice carefully.

A. Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called *protected* health information, or PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI,
- Your privacy rights in your PHI,
- Our obligations concerning the use and disclosure of your PHI.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. If you have questions about this Notice, please contact:

Bouchier & Pritchett Family Practice at 280 Sierra College Dr, Grass Valley, Ca 95945

C. We may use and disclose your PHI in the following ways:

The following categories describe the different ways in which we may use and disclose your PHI.

1. Treatment. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health care operations. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

4. Appointment reminders. Our practice may use and disclose your PHI to contact you and remind you of an appointment.

5. Treatment options. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

6. Health-related benefits and services. Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

7. Release of information to family/friends. Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a baby sitter take their child to the pediatrician's office for treatment of a cold. In this example, the baby sitter may have access to this child's medical information.

8. Disclosures required by law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

D. Use and disclosure of your PHI in certain special circumstances:

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Public health risks. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths,
- Reporting child abuse or neglect,
- Preventing or controlling disease, injury or disability,
- Notifying a person regarding potential exposure to a communicable disease,
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition,
- Reporting reactions to drugs or problems with products or devices,
- Notifying individuals if a product or device they may be using has been recalled,
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information,
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health oversight activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and similar proceedings. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law enforcement. We may release PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement,
- Concerning a death we believe has resulted from criminal conduct,
- Regarding criminal conduct at our offices,
- In response to a warrant, summons, court order, subpoena or similar legal process,
- To identify/locate a suspect, material witness, fugitive or missing person,
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator).

5. Deceased patients. Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organ and tissue donation. Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Serious threats to health or safety. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

8. Military. Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

9. National security. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the president, other officials or foreign heads of state, or to conduct investigations.

10. Inmates. Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

11. Workers' compensation. Our practice may release your PHI for workers' compensation and similar programs.

E. Your rights regarding your PHI:

You have the following rights regarding the PHI that we maintain about you:

1. Confidential communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to Bouchier & Pritchett Family Practice at 280 Sierra College Dr, Grass Valley, Ca 95945 specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to Bouchier & Pritchett Family Practice at 280 Sierra College Dr, Grass Valley, Ca 95945. Your request must describe in a clear and concise fashion:

- The information you wish restricted,
- Whether you are requesting to limit our practice's use, disclosure or both,
- To whom you want the limits to apply.

3. Inspection and copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Bouchier & Pritchett Family Practice at 280 Sierra College Dr, Grass Valley, Ca 95945 in order to inspect and/or obtain a copy of your PHI. Our practice may charge a $25 fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Bouchier & Pritchett Family Practice at 280 Sierra College Dr, Grass Valley, Ca 95945. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment or operations. Use of your PHI as part of the routine patient care in our practice is not required to be documented – for example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to Bouchier & Pritchett Family Practice at 280 Sierra College Dr, Grass Valley, Ca 95945. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before July 1st, 2017. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a paper copy of this notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact Bouchier & Pritchett Family Practice at 280 Sierra College Dr, Grass Valley, Ca 95945 or call the office at 530-477-7390 to arrange.

7. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Dr.Bouchier or Dr. Prtichett at Bouchier & Pritchett Family Practice at 280 Sierra College Dr, Grass Valley, Ca 95945 All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.

8. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time *in writing*. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. *Please note*: we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact Bouchier & Pritchett Family Practice at 280 Sierra College Dr, Grass Valley, Ca 95945