Excela Health Medical Group

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

I acknowledge that I received the Notice of Privacy Practices for Excela Health System and Excela Health Medical Group – includes all Excela Health Medical Group primary care and specialist offices.

Please indicate each method of communication Excela Health Medical Group may use to contact you in regards to your health information and upcoming appointments.

- Messages may be left on my home answering machine
- Messages may be left on my work voicemail
- Messages may be left on my cell phone
- Information may be released only to me and not be left by any electronic method

_____

Name of Patient

_____ _____

Signature of Patient
(or patient's personal representative)

Date of receipt

Personal representative information (if applicable):

_____

Name of personal representative

_____

Relationship to patient (or other authority)

Excela Health Medical Group

AGREEMENT TO PARTICIPATE
SURESCRIPTS PHARMACY SERVICES

I _____ agree to the participation with Surescripts pharmacy services in providing and coordinating electronic prescription transmittal service between Excela Health Medical Group and the pharmacy I select.

I understand the purpose of this agreement is to allow my physician to access my medication history through Surescripts. I understand this agreement will remain in effect for as long as I seek medical care with Excela Health Medical Group, and it will terminate should I transfer my care, request termination of this agreement or after a period of three years without activity with this practice.

_____ _____
Patient Signature Date/Time

_____ _____
Witness Signature Date/Time