			1 at	ient ID#	
Patient Information			\rightarrow Please fill out <u>completely</u>		
Primary Doctor	Preferred PHARMA	CY (specify	v location, if necessar	ry)	
Full LEGAL Name			Gender	Date of Birth	
Last	First	Middle			
Preferred Name	Primary I	Primary Phone		SSN	
Mailing Address				Zip	
	Work Phone				
\Box Single \Box Married \Box Set	eparated Race	Eth	nicity	Religion	
SPOUSE/PARTNER/OTH	ER: Name		Date of Birth	SSN	
Cell Phone	Work Phone		Email		
\Box Single \Box Married \Box Set	eparated DWidowed Race		Ethnicity	Religion_	
SPOUSE/PARTNER/OTHER	: Name	D	ate of Birth	SSN	
Address (if different)		City, St	ate		Zip
Cell Phone	Work Phone		Email		
\Box Single \Box Married \Box S	eparated DWidowed Race		Ethnicity	Religion	
Contact Information	-			\rightarrow CHECK ALL	THAT APPLY
Do we have permission to le. Do we have permission to le.	ave appt. information on your a ave test results or medical info to contact you?	on your ans.	machine/voice mail	with a family member?	□ Yes □ N
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Canyon Medical Group – Notice of Privacy Practices (NPP) Effective May 1, 2025

Your Rights Regarding Your Health Information: As our patient, you have the right to: Access and obtain a copy of your medical records.

Request corrections to your medical records if you believe information is incomplete or incorrect.

Request confidential communication (e.g., using a different phone number or mailing address).

Request restrictions on how your information is used or shared.

Get a list of certain disclosures we have made of your health information.

File a complaint if you feel your privacy rights have been violated, without fear of retaliation.

Our Responsibilities: Canyon Medical Group is required to: Maintain the privacy and security of your protected health information (PHI).

Provide you with this Notice describing our legal duties and privacy practices.

Notify you if a breach occurs that compromises the privacy or security of your information.

Follow the terms of this Notice and obtain your written authorization for certain uses and disclosures.

How We May Use and Share Your Information: We typically use or share your health information in the following ways:

Treatment: To provide and coordinate your healthcare.

Payment: To bill and obtain payment from insurance companies and other payers.

Healthcare Operations: For office management, quality assurance, and administrative purposes.

Other uses and disclosures may include: Public health and safety activities.

Required reporting to health oversight agencies.

Legal proceedings, law enforcement, or as otherwise required by law.

We will not sell your information or use your information for marketing purposes without your written authorization.

Contact Information: If you have questions or concerns about this Notice or your rights, please contact: Canyon Medical Group 1624 North 200 East, Suite 160 Logan, Utah 84341 Acknowledgment of Receipt

I acknowledge that I have received or had access to Canyon Medical Group's Notice of Privacy Practices.

Patient Name (Print):

Signature: ______ Date:

If applicable, Representative Name and Relationship to Patient: