NOTICE OF PRIVACY PRACTICES

PLEASE READ AND SIGN

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The law known as HIPAA (Health Insurance Portability and Accountability Act) requires that all healthcare providers maintain the privacy of the protected health information and provide individuals with notices of its legal duties and privacy practices with respect to protected health information. This office is required to follow the terms of the notice currently in effect.

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Continuity of care is part of treatment and your records may be shared with other healthcare providers to whom you are referred. Information may be shared by paper mail, electronic mail, fax or other methods.

In addition, we may disclose identifiable personal health information about you without your authorization for several reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes such as reporting of communicable diseases, birth, death, injury and child abuse or neglect: for auditing purposes: for research studies: and for emergencies. We may provide information when otherwise required by law, such as for law enforcement or by court order in specific circumstances. Contact with you may also take place in the form of appointment reminders, prescription refills, referrals, test results, etc.

In any other situation, we will ask for written authorization before using or disclosing any identifiable personal health information about you. If you choose to sign an authorization to disclose information, you may later revoke either all or part of the authorization to limit or stop any future uses or disclosure.

You have the right to request a restriction on the use and disclosure of some information. We will accommodate all reasonable requests to the best of our ability. You have the right to receive confidential information by alternate means and alternate locations. You have the right to see and make copies of all information that is contained in your medical record or chart at this office. If you request a copy of your medical record, we may charge you a normal photocopy fee. If you believe that information contained in your medical record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. You have the right to an accounting of disclosures of all protected health information that were released by this office for purposes other than treatment, payment and healthcare operations. You have the right to a paper copy of this notice regardless of whether you have received a prior copy either in printed or electronic format.

Print Name:

Signature: ______________________________________ Date: ________________________

CFC Signature:____________________

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