**HIPAA NOTICE OF PRIVACY PRACTICES**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**Uses and Disclosures:** We will use and disclose elements of your protected health information (PHI) in the following ways:

**Without your signed authorization**

 • Treatment

 • Payment and claim processing

 • Health care operations

 • When release is required by law, including in judicial settings, to health oversight regulatory agencies, and law enforcement.

 • In emergency situations or to avert serious health/safety situations.

 • To medical examiners, coroners or funeral directors to aid in identifying you or to help them in performing their duties.

 • To organ, tissue and other donation organizations, upon or proximate to your death.

 • To contact you about appointment reminders, treatment alternatives and other health related benefits and

 services.

 • To the sponsor of your health plan.

 • All other uses and disclosures by us will require us to obtain from you a written authorization.

**Your rights:** You have the following rights concerning your PHI:

• **Restrictions:** To request restricted access to all or part of your PHI. To do this, you must contact us in writing.

We are not required to grant your request, however.

• **Confidential communications:** To receive correspondence of confidential information by alternate means or

location.

• **Access:** To inspect or receive copies of your protected health information.

• **Amendments:** To request changes made to your PHI. We are not required to grant your request, however.

• **Accounting:** To receive an accounting of the disclosures by use of your PHI in the six years prior to your

request. To do this, you must contact our privacy officer.

• **This notice:** To get updates or reissue of this notice, at your request.

• **Complaints:** To register a complaint in writing to us or Secretary of the U.S. Dept. of Health and Human Services at 200 Independence Avenue, SW, Room 615F, Washington, D.C. 20201 if you feel your privacy rights have been

violated. The law forbids us from taking retaliatory action against you if you complain.

**Our duties:** We are required by law to maintain the privacy of your PHI. We must abide by the terms of this notice or any update OF THIS NOTICE.

For more information about our privacy practices, please contact us directly.

**Effective date:** 08/12/2014

I acknowledge receipt of this notice. I understand that I am financially responsible for paying any unpaid balance and will be responsible for the entire bill if the claims are not covered. I authorize the direct payment of any benefits due me for the services of each visit. I understand the billing is performed electronically, and that the entire amount due will not be available on the date of service.

Sign:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print name of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you are signing as the patient’s representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print your name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Describe your authority:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_