HIPAA PRIVACY POLICY NOTICE

We will keep and record information about your medical condition. We may use this information or disclose this information to others as follows.

We may use or disclose your health information in order to **treat** you. For example, we may advise the health care provider who has given you a prescription of your medical condition. We may also disclose your condition to family members or care-givers who are involved in your medical care.

We may use or disclose your health information in order to receive **payment** for the services we provide to you. For example, we may disclose your condition in order for your insurance company to understand why you received such treatment so that they will pay your claim. We may also disclose your information to our billing department in order to seek payment for services we provide to you.

We may also disclose your health information for our operations. For example, we may review your information in order to evaluate your treatment and our services in order to insure that our care for you now and in the future is the best that it can be. We may use your information to contact you in the future.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

The Right to Inspect and Copy Your Information: You may review and copy your medical records and information. You should make such a request to us at our office address. We have the right to charge a reasonable fee for all copying and mailing expenses.

The Right to Amend: You may ask that we amend your health information if you believe that your information is incomplete or incorrect. A request for an amendment should be made in writing and sent to the above address. You must accompany the request with a reason why you feel the amendment should be made. We may deny your request if it is not written or if you fail to state a reason for the proposed amendment. We may also deny your request if you ask us to amend information that is not part of the information we keep, was not created by us, is not part of the available information for you to inspect and copy or is accurate and complete.

The Right to Know about Disclosures: You have the right to request an accounting of who we have discussed your health information with. The request should be made in writing and sent to the address on the reverse side. You must state a time period for your request, which cannot be longer than 6 years. Your first request every 12 months is free. After that, we may charge you for additional requests.

The Right to Request Restrictions: You may request a restriction or limitation on how and what health information we disclose regarding you for treatment, payment of health operations or to your family or care-givers. We do not have to agree to your request. Requests for restrictions must be made in writing and sent to us. Your request must include a statement of what information you want to limit, whether you want to limit its use, disclosure or both, and to whom you want the limits to apply.

The Right to Confidential Communications: You may request that we communicate with you about medical matters in a certain format or a specific

location. You must request such a confidential communication or specific type or place of communication in writing submitted to us at the address on the reverse side. No reason for this request is necessary, and we will honor all reasonable requests.

The Right to Receive a Copy of this Notice: You may request and receive a copy of this notice (or our current notice) at any time by contacting us at the address on the reverse side and requesting a copy of our “Privacy Policy Notice.”

PLEASE NOTE that we retain the right to alter, amend or change this Notice at any time. Any such revision may be effective on any information we obtain about you in the future or any information that we already have regarding you. A copy of our most current Notice will be on display in our office.

COMPLAINTS regarding the use of your health information should be made to us at the address on the reverse side and/or with the Department of Health and Human Services. All complaints must be submitted in writing. There is no cost or penalty to you for filing a complaint.

I, ________________________________, acknowledge receipt of this Notice of Privacy on this the ________ day of _______________, 200____.

Signed ____________________________________

Patient refused to sign the acknowledgement of this receipt of the Notice of Privacy Policy. Patient was given a copy of the Notice, was offered the opportunity to review and ask questions.

Signed ____________________________________

Date ______________________________________

Notice could not be given to the above named patient because:

____

____

Signed ____________________________________

Date ______________________________________