

NOTICE OF PRIVACY PRACTICES, ACKNOWLEDGEMENT AND CONSENT

The *Health Insurance Portability & Accountability Act of 1996* (“HIPAA”) requires that all medical records and other individually identifiable health information used or disclosed by this organization be kept properly confidential. The patient has the right to understand and control how their health information is used or disclosed.

We may use and disclose patient medical records only for the following purposes:

- Treatment:** providing, coordinating, or managing health care and related services by one or more health care providers.
- Payment:** activities related to obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. (e.g., billing insurance provider for patient visit)
- Health care operations:** conducting quality assessment and improvement activities, auditing functions, cost-management analysis, customer services and as required by law.
- We may create and distribute non-identified health information by removing all references to individually identifiable information.
- We may contact patients to provide appointment reminders, information about treatment alternatives or other health-related benefits and services.
- Any other uses and disclosures may be made only with patient’s written authorization.
- We have the right to change our *Privacy Practices* from time to time. Patients may request a current copy by writing to address indicated above.

Patients have the following rights with respect to their protected health information. Patient may exercise these rights by submitting a written request to the address indicated above, attention Office Manager:

- The right to request restriction on certain uses and disclosures of protected health information, including those related to family members, other relatives, close personal friends, or any other person identified by patient.
- The right to reasonable requests to receive confidential communications of protects health information from this organization by alternative means or locations.
- The right to inspect and copy protected health information.
- The right to amend protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to request a paper copy of this notice.

I hereby acknowledge that I have been given the right to review this organization’s Privacy Practices and give my consent to use my protected health information under the conditions provided.

Patient or Guardian

Date

You have my permission to leave messages for me on my home phone, cell phone or email.

Patient or Guardian

Date