Notice of Privacy Practices & Acknowledgement of Notification

THIS NOTICE DESCRIBES HOW MEDIAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED & HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW THE INFORMATION CAREFULLY.

The Health Insurance Portability & Accountability Act (**HIPPA**) requires all health care records & other individually identifiable health information used or disclosed by us in any form; whether electronically, on paper, or orally; be kept confidential. This federal law gives you, the patient, significant right to understand & control how your health information is used. **HIPPA** provides penalties for covered entities that misuse Protected Health Information (**PHI**). As required by **HIPPA** Privacy Rule 45 C.F.R. 164.520 we have provided this information on how we are required to maintain the privacy of your **PHI** and how we may disclose this information.

Without specific written authorization we ARE permitted to use & disclose your PHI for the purpose of *treatment*, *payment*, & *health care operations*.

TREATMENT: Providing, coordinating, or managing health care or related services by one or more health care providers. For example, we may need to share information with other health care providers or specialists involved in the continuity of care.

PAYMENT: Any activities needed for obtaining reimbursement for services, confirmation of coverage, billing, or collection activities, and utilization review. For example, we may disclose treatment information when billing a medical plan for your medical services.

HEALTHCARE OPERATIONS: includes, but is not limited to, all the business aspects of running our practice and may be used for training purposes or quality assessment/risk management.

We will not release medical records to anyone without a signed Release of Information except in certain situations.
Your **PHI** may be disclosed for public health oversight activities, judicial or administrative proceedings, in response to subpoena or court order; to military authorities of the Armed Forces personnel; to federal officials for lawful intelligence, counterintelligence, and other national security activities; to correctional and/or law enforcement officials. If you revoke such authorization in writing, we are required to honor and abide that written request, except to the extent that we have already taken actions relying on your authorizations.

YOU HAVE CERTAIN RIGHTS IN REGARDS TO YOUR PHI, WHICH CAN BE EXERCISED BY PRESENTING A WRITTEN REQUEST TO THE CLINIC COORDINATOR.

- The right to request restrictions on certain uses & disclosures of **PHI** including those related to disclosure to relatives, friends, or anyone else identified by you. We are, however, not required to agree to a requested restriction.
- The right to request & receive confidential communications or **PHI** from us by alternative means or an alternative location.
- The right to access, inspect, or obtain a copy of your **PHI**. We may however, deny your request in certain situations.
- The right to receive an accounting disclosure of **PHI** made outside of treatment, payment, or health care operations as based on your previous authorization.
- The right to obtain a copy of this notice upon request.

This notice went into effect as of April 14, 2003 and we are required to abide by the terms of HIPPA. If there are any changes to this Notice of Privacy Practices, it will be posted on the effective date and you may request a copy. You have the right to file a formal, written complaint with us or with the Department of Health & Human Services, Office of Civil Rights, in the event that you feel your privacy has been violated. If you have any questions, please do not hesitate to contact the clinic coordinator. For more information about **HIPPA** or to file a complaint, contact the above mentioned people at: The U.S. Dept of Health & Human Services, Office of Civil Rights, 200 Independence Ave SW Washington D.C. 20201, or 1-877-696-6775 toll free.

I acknowledge that I can receive a copy of the Office's Notice of Privacy Practices.

Signature: Patient OR Legal Guardian	**Date**
Printed Name	**Relationship (self, parent, legal guardian, etc)**