

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

This notice describes how health information about You may be used and disclosed, and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

I understand that, under the health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

. Conduct, plan and direct my treatment and follow-up among the various health care providers who may be involved in your treatment directly and indirectly.

. Obtain payment from third-party payers.

. We may use or disclose health information to provide appointment reminders (voice mail, letters, postcards), or in connection with our health care operations including quality assessments, improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioners performance, certification, licensing or credentials.

. We may use or disclose health information to notify or assist in the notification of a family member, your personal representative or another person responsible for your care, of your location, your general condition or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. We will use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

. We may use or disclose your health information when we are required to do so by law.

. We may disclose your health information to appropriate authorities to the extent necessary to avert a serious threat to your health or safety, or the health or safety of others, if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes.

I have received, read and understand your notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this Office has the right to change its notice of privacy practices from time to time and that I may contact this Office at any time at the address above to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information, or in response to a request you made to amend or restrict the use or disclosure of your health information, or to have us communicate with you by alternative means or at alternative locations, you may complain to us using our contact information.

Patient Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_

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