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.

PLEASE REVIEW IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, significant rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health information and how we may disclose your health information.

- Treatment means providing, coordinating, or managing health and related services by one or more healthcare providers.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review.
- Health Care Operations includes business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request.

- The right to inspect and copy your information;
- The right to request corrections to your information;
- The right to request that your information be restricted;
- The right to request confidential communications;
- The right to report of disclosures of your information; and
- The right to a paper copy of this notice.

This notice is effective as of April 1, 2015, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with our office or with the Department of Health and Human Services, Office of Civil Rights, about the violations of the provisions of this notice and procedures of our office. We will not retaliate against you for filing a complaint. I acknowledge receipt of this notice:

Patient Name: _____ Date:_____

Signature: _____