NOTICE OF PRIVACY PRACTICES

Effective Date: _____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Commitment to Your Privacy

Our medical practice is committed to protecting the privacy and confidentiality of your health information. We are required by law to maintain the privacy and security of your protected health information (PHI), provide you with this Notice of Privacy Practices, and follow the privacy practices described in this notice. We will notify you as required by law if a breach occurs that may have compromised the privacy or security of your information.

How We May Use and Disclose Your Health Information

Treatment. We may use and share your health information with physicians, nurses, laboratories, pharmacies, specialists, hospitals, and other healthcare professionals involved in your care.

Payment. We may use and disclose your health information to bill and obtain payment from health plans, insurance companies, or other entities responsible for payment for your healthcare services.

Healthcare Operations. We may use and disclose your health information for activities necessary to operate our practice, including quality assessment, staff training, credentialing, auditing, compliance, and administrative activities.

Appointment Reminders and Communications. We may contact you regarding appointments, test results, treatment, follow-up care, healthcare services, or other matters related to your care, as permitted by law.

As Required or Permitted by Law. We may disclose health information when permitted or required by applicable law, including certain disclosures involving public health activities, health oversight, judicial or administrative proceedings, law enforcement, workers' compensation, prevention of serious threats to health or safety, and other legally authorized purposes.

Uses and Disclosures Requiring Authorization

For uses and disclosures not otherwise permitted or required by law, we will obtain your written authorization when required. You may revoke an authorization in writing at any time, except to the extent that we have already acted in reliance on it. Certain categories of health information may receive additional protection under federal or state law.

Your Rights Regarding Your Health Information

Subject to applicable law, your rights may include the right to inspect and obtain a copy of your medical and billing records; request corrections or amendments; request confidential communications; request certain restrictions; request an accounting of certain disclosures; obtain a paper copy of this notice; and choose someone with appropriate legal authority to act on your behalf. We will not retaliate against you for exercising your privacy rights or filing a complaint.

Our Responsibilities

We are required to maintain the privacy and security of your protected health information, provide this notice, follow the terms of the notice currently in effect, and provide breach notification when required by law. We reserve the right to change this notice and our privacy practices as permitted by law. Any revised notice may apply to information we already have as well as information received in the future.

Questions or Complaints

If you have questions about this notice, wish to exercise your privacy rights, or believe your privacy rights have been violated, please contact:

Privacy Officer: _____

Practice Name: _____

Address: _____

Phone: _____

You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights. You will not be penalized or retaliated against for filing a complaint.

ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I have received or have been offered a copy of this medical practice's **Notice of Privacy Practices**.

Patient Name: _____

Date of Birth: _____

Patient/Representative Signature: _____

Printed Name: _____

Relationship to Patient (if applicable): _____

Date: _____

Office Use Only

If the patient's acknowledgment could not be obtained, document the reason below:

_____

_____

Staff Name/Initials: _____ **Date:** _____