

Patient Name: _____ Date: _____

HIPAA NOTICE OF PRIVACY PRACTICE

THIS NOTICE DESCRIBE HOW MEDICAL INFORMATION ABOUT YOU MAY USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for another purposes that are permitted or required by law. "Protect Health Information" is information about you, including demographic information that may identify you and the related to your past, present or future physical or mental health or condition and related care services.

Use and Disclosure of Protected Health information:

Your protected health information may be used and disclosed by your physician, our staff and other outside of our office that are involved in your care and treatment for the purpose of providing health care services to you pay your health care bill, to support the operation of the physician's practice and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third part. For example: We would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example: Your health care information may be provided to a physician to Whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: You protected health information will be used, as need to obtain payment for your health care services. For example: Obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as need, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fund raising activities and conduction or arranging for other business activities. For example: We may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations with out your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation.

Required uses and disclosures under the law, we must make disclosures to you when required by The Secretary of The Department of Health and Human Services to investigate or determine our compliance with the requirement of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization at any time in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Signature of Patient Representative

Date

Printed Name