NOTICE OF PRIVACY PRACTICES AND ACKNOWLEDGEMENT

This notice describes how your health information may be used and disclosed. Please Review it carefully.

YOUR RIGHTS

You have certain rights with respect to your health information, subject to legal limitations, including:

- Obtaining an electronic or paper copy of your record. We will provide a copy or summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Asking us to correct incorrect or incomplete information. We may say "no," but if we do, we'll tell you why in writing within 60 days.
- Requesting confidential communications or asking us to contact you in a specific way (e.g., home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.
- Asking us to limit what we use or share for treatment, payment, or our operation. We are not required to agree to your request, and we may say "no." If, however, you pay for a services or item out-of-pocket in full, you can request that we not share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
- Obtaining a list (accounting) of those with whom we've shared your information for six years prior to the date you ask, who we shared it with, and why. The list will not include disclosures for treatment, payment, and health care operations, and certain other disclosures (e.g. made at your request). We'll provide one accounting a year for free, but will charge a reasonable, cost-based fee if you ask for additional accountings.
- Obtaining a paper copy of this notice at any time, even if you agreed to receive the notice electronically.
- Designating someone to act for you. If you have a medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act on your behalf before we take any action.
- Filing a complaint if you feel we have violated your rights by contacting: U.S. Department of Health and Human Services Office for Civil Rights, 200 Independence Ave, S.W., Washington, D.C. 20201, 1-877-696-6775, www.hhs.gov/ocr/privacy/hipaa/complaints. We will not retaliate against anyone for filing a complaint.

YOUR CHOICES

- You have the right and choice to have us share information with family, friends, or others involved in your care; share information in a disaster relief situation; or include your information in a hospital directory.
- We will not sell your information or share it for marketing unless you give us written permission.
- We will not share psychotherapy notes for unless you give us written permission.

If you are not able to tell us your choice, we may share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

OUR USES AND DISCLOSURES

- We can use your health information and share it with others for treatment, payment, and health care operations. This includes sharing information with others who are treating you, to bill and get paid, and to run our practice and improve care.
- We are also allowed or required to share your information in other ways, such as:
  - Providing you with information related to your health;
  - Contacting you regarding appointments, treatment alternatives, or other health related services;
  - Incidental uses or disclosures (*e.g.*, listing your name on a sign-in sheet, etc.);
  - Compliance with all laws (including reports of adverse reactions, suspected abuse, neglect or violence);
  - Providing information to law enforcement or correctional institutions;
  - Providing information to a coroner, medical examiner, funeral director, or for organ procurement;

Continued on Back

- Public health activities when requested by a public health authority or the FDA.
- Responding to health oversight agencies;
- Responding to court or administrative orders, subpoenas, discovery requests or lawful process;
- Research activities;
- When necessary to avert a serious threat to health or safety;
- Military affairs, veterans affairs, national security, intelligence, Department of State, or presidential protective service activities;
- Providing information regarding your location, general condition or death to disaster relief agencies;
- Providing information for workers' compensation claims; or
- Informing a family member, other relative, or close personal friend when:
    - Information is relevant to the individual's involvement with your care;
    - Notification of your location, general condition or death;
    - To assist in your heath care (pick-up prescriptions or documents, follow-up care instructions, etc.).

- Our practice will make other uses and disclosure of your protected health information only after obtaining your written authorization. If you authorize a use not contained in this notice, you may revoke your authorization at any time by notifying us in writing.

OUR RESPONSIBILITIES

- We are required to maintain the privacy and security of your protected health information and to let you know promptly if a breach occurs that may compromise the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us in writing that we can. If you tell us we can, you may change your mind at any time, but please let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

PATIENT ACKNOWLEDGEMENT

I acknowledge receiving a copy of this notice regarding the use and disclosure of my health information.

_____ _____

Signature of Patient/Legal Guardian Date

_____ _____

Print Patient Name (required) Print Legal Guardian Name (if necessary)