



Notice of Privacy Practice

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.***

Federal and state law requires us to maintain the privacy of your health information. That law requires us to give you this notice about privacy practices, our legal duties and your rights to make revisions to this policy. Should revisions be made, you will be notified in writing and a copy of the revised policy will be made available at your request. You may request a copy of this notice at any time.

Treatment/Disclosure: We may use your health information for treatment or disclose it to another health care provider who will be providing treatment to you. *Your signature on this form provides authorization to use and disclose your personal health information to other healthcare providers by fax, e-mail, telephone, or letter. You may decline this disclosure with written notice and signature.*

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the federal Privacy Rules for its payment activities.

Health Care Operations: We may use and disclose your health information for our health care operations such as quality assessment and improvement activities, protocol development, training information to detect or prevent health care fraud and abuse.

On Your Authorizations: Your authorization allows us to communicate your personal health information with your immediate family and/or significant other. Your signature also authorizes communication of personal health information to yourself by voicemail, text message, postcard, letter, e-mail, or fax. You may decline this communication with a separate signature.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders such as voice mail messages, text messages, postcards, letters, e-mail or fax.

I have read the *Notice of Privacy Practices* and agree to the policies.

Patients Name

Patient (or Guardian) Signature

Date