NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal law that requires all medical records and other individual health information that is used or disclosed by us in any form (on paper, electronically, or verbally) are kept properly confidential. In summary, HIPAA gives you the following rights.

- The right to request on certain uses and disclosures of protected health information including disclosures to family members, other relatives, close personal friends or any other personal identified by you.
- The right to reasonable requests to receive confidential communications of protected health information to us.
- The right to inspect and copy your protected health information.
- The right to amend you protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of our Notice of Privacy Practices.

We may disclose your medical records for each of the following purposes:

- **Treatment: This includes providing, coordinating, or managing health care and related services by one or more health care providers. For example, we may disclose protected health information to your family physician, diabetic physician, referring physician or any other physician that treats you.**
- **Payment: This involves such activities as obtaining reimbursement for services, confirming insurance coverage, billing agency, collection agency, or credit agency, and utilization review. For example, we may provide protected health information to your insurance company.**
- **Health Care Questions: This includes the business of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. For example, we may utilize protected health information for a quality assessment review.**

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorizations in writing and we are required to honor and abide by that written request. If you feel that our privacy protections have been violated, you have the right to file a written complaint with our office or with the Department of Health and Human Services.

I acknowledge that I was provided a chance to read or a copy of the Notice of Privacy Practices and that I understood the notice.

Patient name (Please Print) ______________________________

Patient signature ______________________________ *Date* ______________