

HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Our Obligations:

We are required by law to maintain the privacy of protected health information, to give you notice of your legal duties and privacy practices regarding health information about you, and to follow the terms of our notice that is currently in effect.

Special Situations:

As required by law, we will disclose health information when required to do so by international, federal, state, or local law.

To avert a serious threat to health or safety, we will disclose health information when necessary to prevent a serious threat to your health and safety, or the public, or another person.

Disclosure, however, will be made only to someone who may be able to help provide treatment.

Your Rights:

You have the following rights regarding the health information we have about you.

The right to inspect and copy. The right to amend. The right to an accounting of disclosure. The right to request restrictions. For example, you can ask that we not share information about your particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to our Privacy Officer. We are not required to agree with your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment. The right to request confidential communication. And the right to a paper copy of this notice.

Changes to this Notice:

We reserve the right to change this notice and make the new notice apply to health information we already have as well as any information we receive in the future.

Complaints:

If you believe your privacy has been violated, you may file a complaint with our office or the Secretary of the Department of Health and Human Services. All complaints must be made in writing. You will not be penalized for filing a complaint.

By signing my name below, I acknowledge my understanding and my agreement to its terms.

Patient Signature

Date