HIPAA NOTICE OF PRIVACY PRACTICES

I. This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully!

II. It is our legal duty to safeguard your protected health information (PHI).

By law, we are required to insure that your PHI is kept private. The PHI constitutes information created or noted by us that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. We are required to provide you with this Notice about our privacy procedures. This Notice must explain when, why, and how we would use and/or disclose your PHI.

Use of PHI means when we share, apply, utilize, examine, or analyze information within our practice; PHI is disclosed when we release, transfer, give, or otherwise reveal it to a third party outside our practice. With some exceptions, we may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, we are always legally required to follow the privacy practices described in this Notice. Please note that we reserve the right to change the terms of this Notice and our privacy policies at any time. Any changes will apply to PHI already on file with us. You may also request a copy of this Notice from your provider.

III. How we will use and disclose your PHI.

We will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of our uses and disclosures, with some examples.

A. Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. We may use and disclose your PHI without your consent, unless otherwise required by law, for the following reasons:

1) For treatment. We may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Information exchanged between providers will first be approved via your signed Release of Information Form.

2) For health care operations. We may disclose your PHI to facilitate the efficient and correct operation of our practice.

3) To obtain payment for treatment. We may use and disclose your PHI to bill and collect payment for the treatment and services we provided you.

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B. Other Uses and Disclosures Require Your Prior Written Authorization.
In any other situation not described above, we will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures (assuming that we haven't taken any action subsequent to the original authorization) of your PHI by us.

IV. What Rights You Have Regarding Your PHI.

A. The Right to See and Get Copies of Your PHI. In general, you have the right to see your PHI that is in our possession, or to get copies of it; however, you must request it in writing. Under certain circumstances, we may feel we must deny your request, but if we do, we will give you, in writing, the reasons for the denial. We will also explain your right to have our denial reviewed.

B. The Right to Choose How We Send Your PHI to You. It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). We are obliged to agree to your request providing that we can give you the PHI, in the format you requested, without undue inconvenience.

C. The Right to Get a List of the Disclosures We Have Made. You are entitled to a list of disclosures of your PHI that we have made. The list will not include uses or disclosures to which you have already consented, i.e., those for treatment, payment, or health care operations, or sent directly to you. Disclosure records will be held for six years.

D. The Right to Amend Your PHI. If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that we correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of our receipt of your request. We may deny your request, in writing, if we find that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of our records, or (d) written by someone other than us. Our denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and our denial be attached to any future disclosures of your PHI. If we approve your request, we will make the change(s) to your PHI. Additionally, we will tell you that the changes have been made, and we will advise all others who need to know about the change(s) to your PHI.

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E. The Right to Get This Notice by Email You have the right to get this notice by email. You have the right to request a paper copy of it, as well.

V. How to complain about our privacy practices.

If, in your opinion, we may have violated your privacy rights, or if you object to a decision we made about access to your PHI, you are entitled to file a complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W. Washington, D.C. 20201. If you file a complaint about our privacy practices, we will take no retaliatory action against you.

VI. Effective Date of This Notice

This notice went into effect on November, 2006.

I acknowledge receipt of this notice.

Patient Name:_____

Patient Signature: _____

Date: _____/_____/_____

I acknowledge receipt of this notice.

Patient Name:_____

Patient Signature: _____

Date: _____/_____/_____

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