

HIPAA PRIVACY POLICY - PAGE 1 of 3

Patient Name _____ Date of Birth _____ SSN _____

Phone Number _____ Work Number _____ Cell Number _____

Street Address _____ City _____ State _____ Zip _____

Employer Name _____ Employer Phone Number _____

In general, the HIPAA privacy rule gives individuals the right to request a restriction of their health information.

The individual is also provided the right to request confidential communications or that a communication of PHI (Protected Health Information) be made by alternative means, such as, sending information to the individual's office instead of their home.

I wish to be contacted in the following manner (check all that apply):

Home Telephone: _____
OK to leave a message with details: _____
Leave message with only call back #: _____
OK to speak to spouse: _____ Other: _____

Written Communication: _____
OK to mail to my home: _____
OK to mail to my work: _____
OK to fax to designated #: _____

Work Telephone: _____
OK to leave message with details: _____
Leave message with only call back #: _____

Emergency Contact: _____ Relation: _____
Phone #: _____

I give the above doctors permission to use and disclose PHI necessary to carry out TPO (treatment payment or operations). This also indicates a "Good Faith Effort" was made on behalf of the doctors named above.

By signing this form, I understand that the privacy practices of the office have been disclosed to me. This information will stay on record for 6 years.

Signature: _____ Date: _____

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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. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 7, 2007 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, providing such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practice, or for additional copies of this notice, please make your request to a member of our office.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

TREATMENT: We may use and disclose your health information to a physician or other healthcare provider providing treatment to you.

PAYMENT: We may use and disclose your health information to obtain payment for services we provide to you.

HEALTHCARE OPERATIONS: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

YOUR AUTHORIZATION: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

TO YOUR FAMILY AND FRIENDS: We must disclose your health information to you as described in the patient rights section of this notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

PERSONS INVOLVED IN CARE: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your incapacity or emergency circumstances, we will disclose health information based on a determination using our healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.

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MARKETING HEALTH-RELATED SERVICES: We will not use your health information for marketing communications without your written authorization.

REQUIRED BY LAW: We may use or disclose your health information when we are required to do so by law.

ABUSE OR NEGLECT: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

PATIENT RIGHTS

ACCESS: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request access by contacting our office and we will provide one. We will charge you a reasonable cost-based fee for expenses such as copies and staff time and the charge will be ten cents per page plus postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee in order to provide the information in the alternative format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us for full explanation of our fee structure.

DISCLOSURE ACCOUNTING: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 7, 2007. If you request this accounting more than once in a 12-month period, we may charge a reasonable, cost-based fee for responding to these additional requests.

RESTRICTION: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these restrictions, but if we do, we will abide by our agreement (except in an emergency).

ALTERNATIVE COMMUNICATION: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing) Your request must specify the alternative means and location and provide satisfactory explanation how payments will be handled under the alternative means or location your request.

AMENDMENT: You have the right to request that we amend your health information (Your request must be in writing and it must explain why the information should be amended). We may deny your request under certain circumstances.

ELECTRONIC NOTICE: If you receive this notice on our website or by electronic mail (e-mail) you are entitled to receive this notice in written form. Please make the request for a written form to a member of our staff.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclose of your health information or to have us communicate with you by alternative means or at an alternative location, you may complain to us using the contact information listed at the end of this notice. You may also submit a written complaint with the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon your request.

We support your right to privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.