

Notice of Privacy Practice

Our Notice of Privacy Practice provides information about how we use and disclose protected health information about you. The notice contains a Patient Rights section describing your rights under the law. You have the right to review and request a copy of our notice before signing this. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request how protected health information about you is used or disclosed for treatment, payment or health care options. WE are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such revocation shall not affect any disclosure we have already made under any prior consent. This practice provides this form to comply with the HIPPA Act of 1996.

I UNDERSTAND THAT THIS INFORMATION SERVES AS:

- A basis for planning my care and treatment
- A means for communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payor can verify that services billed were actually provided.
- A tool for routine healthcare operations, such as assessing quality and reviewing the level of care of healthcare professionals.

I request the following restrictions to the use or disclosure of my health information: _____

Patient / Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____