NOTICE OF PRIVACY PRACTICES

This notice describes how health information about your child (as a patient of this practice) or you (as a patient of this practice) may be used and disclosed and how you have access to this information. Please review this notice carefully.

Our Commitment to Privacy

_____ is dedicated to maintaining the privacy of its patients' protected health information (PHI). We are required by law to maintain the confidentiality of this health information. We are also required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning PHI. We reserve the right to amend, our Notice. By federal and state law we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

Use and Disclosure of PHI

Our practice may use and disclose PHI for the purposes of treatment, payment and business operations. The following categories describe the different ways in which we may use and disclose PHI for these purposes.

- Treatment
- Payment
- Health Care Operations
- Release or Sharing of Information
- The Rights of Minors and Personal Representatives
- Release of Information to Business Associates
- Release of Information Required by Law
- Research Purposes
- Marketing Purposes

Your Health Information Rights

You have the following rights regarding the PHI that we maintain about your child or you.

- Requesting Restrictions on PHI
- Inspection and Copies of PHI
- Amendment of PHI
- Accounting of Disclosures
- Right to a Paper Copy of This Notice
- Right to File a Complaint
- Right to Provide an Authorization of Other Uses and Disclosures

If you have any questions regarding this notice or our health information privacy policies, please contact _____ at _____.

I have read this office's Notice of Privacy Practices, which explains how my medical Information will be used and disclosed. I understand that I am entitled to receive a copy of your Notice of Privacy Practices.

_____

Name of Patient (Print or Type)

_____

Date

_____

Signature of Patient or Patient Representative (Representative's signature is required if the patient is a minor or an adult who is unable to sign this form)

_____

Relationship of Patient Representative to Patient