NOTICE OF PRIVACY PRACTICES

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.

We are required by law to maintain the privacy of protected health information and to provide individuals with the notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information and your rights with respect to this information.

USES AND DISCLOSED OF YOUR HEALTH INFORMATION:

TREATMENT: We may use medical information about you to provide you medical care. We disclose medical information to other physicians or other health care providers who will provide services which we do not provide. We may also share this information with a pharmacist who needs to dispense a prescription or laboratory that performs test.

PAYMENT: We may use and disclose medical information about you to your insurance company in order to obtain payment for the services we provide. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

HEALTHCARE OPERATIONS: We may use & disclose your health information in connection with the following:

1) To review and improve the quality of care we provide, or the competence and qualifications of our professional staff.
2) To request that your health plan authorize services and or referrals.
3) As necessary for medical reviews, legal services and audits; including fraud and abuse detection.
4) Compliance programs and business planning and management.
5) For clearing houses or health plans that have relationship with you when they request information to help them with their quality assessment and improvement activities, their efforts to improve or reduce healthcare costs.
6) For review of compliance, qualifications and performance of healthcare professionals, training programs, accreditations, and certification or licensing activities.

YOUR AUTHORIZATION: You may give us written authorization to use and disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or payment for your healthcare, but only if agree that we may do so. 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. Your location, your general condition or death. You may revoke your authorization at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect.

REQUIRED BY LAW: We will use and disclose your health information, but we will limit this information to the relevant requirements of the law when the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceeding, or to law enforcement officials. We will further comply with the requirements set forth below concerning those activities.

1) Preventing or controlling disease, injury or disability.
2) Reporting child, elder, dependent adult abuse or neglect
3) Reporting domestic violence.
4) Reporting to the food and drug administration problems with products and reactions to medications.
5) Reporting disease or infection exposure
6) When we report suspected elder or dependent abuse or domestic violence, we will inform you or your personal representative promptly unless we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.
NOTICE OF PRIVACY PRACTICES
Patient:

Our Notice of Privacy Practices (Notice) provides information about how we may use and disclose protected health information about you. You have the right to receive and review our Notice before signing this acknowledgment. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy.

By signing this form, you acknowledge that you have been informed of our uses and disclosures of protected health information about you for all of the purposes set out in our Notice.

By signing this form, you also acknowledge that a copy of our Notice has been provided to you, that you understand the contents of our Notice and how it applies to you, and that all of your questions regarding the contents of our Notice have been answered.

_________________________________________  ______________________________________
Signature                                      Date