Notice of Information Practices

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days of request to do so. There may be a reasonable cost-based fee for photocopying, postage and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

Our practice conforms to HIPPA.

Patient Signature (if Patient is a Minor, Signature of Guardian or Responsible Party)

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Office Manager

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If Patient is Medicare or Medicaid Patient:

I certify that the information given by me in applying for payment under Title XVIII and/or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration, or its intermediary carriers, any information needed for this or related Medicare or Medicaid claims.

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Patient's Name (please print)

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Patient's Signature (if Patient is a Minor, Signature of Guardian or Responsible Party)

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If Patient is a Minor (Name of Guardian or Responsible Party) (please print)

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Witness Signature

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Date