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NOTICE OF PRIVACY PRACTICES

This notice describes how information about you as a patent of this practice may be used and disclosed and how to access your health information. This is required by the Privacy Regulations created as result of the Health Portability and Accountability Act of 1996(HIPPA).
My patient records are kept confidential, secured and out of reach or unauthorized persons. A written signed and dated release by the patient/guardian must be obtained prior to the release of medical records. We are required by law to maintain the confidentiality of your medical records. However, the law provides for differing circumstances according to the following information.

The following information may require me to use or disclose your health information:

To Provide treatment: With your consent, I may need to share health information with referring physicians, physician assistants or nurse navigators in order to provide the most comprehensive and coordinated care for you.

For you to be reimbursed for payment: Although my practice is a fee for service, which means I do not bill insurance or Medicare, if you intend on submitting a super bill for reimbursement to your insurance or health savings plan, they may require certain information in order to reimburse you. We will review this carefully so that you understand what will be sent before you decide to submit for reimbursement.

Communications: Consent for contact by telephone, email, text or postal mail is included in your new patient package and will be obtained prior to me contacting you for reasons such as, appointment reminders or rescheduling, or responding to your messages.

Required by Law: I may disclose your health information to public health authorities and health oversite agencies that are authorized by law to collect information when required to do so by law enforcement officials. Lawsuits and similar proceedings in response to a court order or administrative order, when necessary to reduce or prevent a serious threat to your health and safety or to another individual or the public, for workers compensation and other similar programs.

I, _____**(Please Print Name)**
have received and have had the opportunity to read and discuss the contents of this privacy notice and understand the handling of my private health information and the possible limitations involved.

_____

Signature. **Date**