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SUMMARY OF PRIVACY PRACTICES

This summary of our privacy practices contains a condensed version of our Notice of Privacy Practices.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you and the services and/or items we provide to you as our patient. By law, we are required to make sure that your protected health information be kept private.

How will we use or disclose your information? Here are a few examples (for more detail please refer to the Notice of Privacy Practices that follows this summary):

- For medical treatment
- To obtain payment for our services
- In emergency situations
- For appointment and patient recall reminders
- To run our Practice more efficiently and ensure all our patients receive quality care
- To avert a serious threat to health or safety
- For workers' compensation programs
- In response to certain requests arising out of lawsuits or other disputes

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our office manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You have certain rights regarding the information we maintain about you. These rights include:

- The right to inspect and copy
- The right to amend
- The right to an accounting of disclosures
- The right to request restrictions
- The right to a paper copy of the notice
- The right to request confidential communications

For more information about these rights, please see the detailed Notice of Privacy Practices.

I acknowledge and agree that the Practice may disclose my protected health information and medical record information to the following individuals who are either my family members, legal representatives, guardians, health care surrogates, or have power of attorney on my behalf: _____

_____

_____

I agree and consent to the Practice releasing information to me in the following alternative manners **(please initial the appropriate spaces below):**

_____ Via regular mail with any envelopes being marked personal and confidential and addressed to me.
Initials

_____ Via telephone, if I contact the Practice and provide the appropriate information (including my name, social security number and unique personal identifier).
Initials

I have read and understand the information in this consent. I, the patient or the authorized party to act on the behalf of the patient, sign this document verifying consent to the above terms.

Date: _____ Time: _____ AM/PM

x _____

Signature of Patient or authorized representative

_____

Please print name

- Please explain Representative's relationship to the Patient and include a description of Representative's authority to act on behalf of the Patient:

_____

_____

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