NOTICE OF PRIVACY PRACTICES
CONSENT & ACKNOWLEDGEMENT FORM

The Health Insurance Portability and Accountability Act require that we disclose certain information to our patients regarding the privacy of their medical information and records; as well as our policies regarding the treatment of this information.

Your medical information, records and documents are of a highly confidential nature. In the course of providing services to you, this office will create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for services and to conduct day to day health care operations.

Notice of Privacy Practice This document represents our Notice of Privacy Practices. You have received two copies of this document. Please read it in its entirety, sign and return one copy to our office

Right to Inspect & Obtain Medical Records Our office has established policies and procedures relating to patients obtaining copies of their medical records. Appropriate charges will apply, as well as the patient's signed consent for us to provide such documentation. If parties other than the patient request these records, a signed release/consent is required.

Right to Amend/Append Medical Records State and Federal law provide guidelines in which patients may amend or append their medical records. All documentation in the patient's medical record will be done in accordance with all applicable laws.

Right to Authorize Certain Non-Treatment Disclosures Patients have the right to request that disclosure of their condition and/or treatment is limited as provided by law. Restrictions on disclosures to family members (including parents), employer(s), marketing or advertising affiliates, research organizations, etc. can be made directly with the physician. Verbal/Written approval to disclose protected health information will be obtained prior to disclosure.

Right to Request Restrictions on Use of Medical Records You have the right to request, in writing, specific restrictions on the use of your medical records and protected health information. Upon receipt of such request(s), we will restrict disclosure as provided by applicable law.

Right to Request Alternative Channels of Communication If you wish for us to communicate with you via alternative channels of communication, please make these requests in writing, including the method through which you wish us to contact you. It is our policy to send mail to the address provided on our patient demographics forms, to contact you by telephone at either your home, cellular, or work telephone numbers, and to leave non-descriptive messages via answering machine. If you prefer an alternate channel of communication, again, please put your specific requests in writing. If you prefer to have your results sent to you via e-mail, please write your e-mail address here:____

Persons to whom you consent for protected health information to be disclosed to:

Name	Relationship to Patient	Phone Number
______________________	________________________	___________________

I have read this document and understand it. I consent to the use and disclosure of my personal health information for purposes of treatment, payment and healthcare operations. I have received a copy of the Notice of Privacy Practices from this office.

Received (Signature of Patient or Patient's Representative): **Date:**

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