Privacy Notice
HIPPA NOTICE OF PRIVACY PRACTICES

1.Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

TREATMENT:We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

PAYMENT: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

HEALTHCARE OPERATIONS: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activites. For example,we amy disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose you protected health information,as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situatuions include: as required by law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements:Legal Poceedings: Law Enforcements: Coroners, Funeral Directors, and Organ Donation: Research: criminal activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of health and human services to investigate or determine our compliance with the requirements of Section 164.500

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES will be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

YOU MAY REVOKE THIS AUTHORIZATION, at any time, in writing, except to the extent that toyur physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS
Following is a statement of your rights with respect to your protected health information.

YOU HAVE THE RIGHT TO INSPECT AND COPY YOUR PROTECTED HEALTH INFORMATION. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health inforamtion that is subject to lae that prohibits access to protected health information.

YOU HAVE THE RIGHT TO REQUEST A RESRTICITON OF YOUR PROTECTED HEALTH INFORMATION. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payement or healthcare operations. You may also request that any part of your protected health information not be disclosed to famly members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restiction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

YOU HAVE THE RIGHT TO REQUEST TO RECEIVE CONFIDENTIAL COMMUNICATIONS FROM US BY ALTERNATIVE MEANS OR AT AN ALTERNATIVE LOCATION. YOU HAVE THE RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE FROM US, upon request, even if you have agreed to accept this notice alternatively i. e. electonically.

YOU MAY HAVE THE RIGHT TO HAVE YOUR PHYSICIAN AMEND YOUR PROTECTED HEALTH INFORAMTION. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

YOU HAVE THE RIGHT TO RECIEVE AN ACCOUNTING OF CERTAIN DISCLOSURES WE AHVE MADE, IF ANY, OF YOUR PROTECTED HEALTH INFORAMTION.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

COMPLAINTS

You may complain to us or to the secretary of Health and Human Services if you believe your rights have been violated by us. You may file a compaint with us by notifying our privacy contact of your compaint. WE WILL NOT RETALIATE AGAINST YOU FOR FILING A COMPLAINT.

This notice was published and becomes effective on/or before APRIL 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowlegement that you have received this Notice of our Privacy Prractices:

Print Name:_____

Signature:

Date: