

NOTICE OF PRIVACY PRACTICES

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

II. **Safeguarding Your Protected Health Information**

Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for health care is considered "Protected Health Information" (PHI). We will extend certain protections to your PHI. This Notice explains how, when and why we may use or disclose your PHI. Except in specified circumstances, we will only use or disclose the minimum necessary PHI to accomplish the intended purpose of the use or disclosure.

III. **How We May Use and Disclose Your Protected Health Information**

We use and disclose PHI for a variety of reasons. We may use and/or disclose your PHI for purposes of treatment or our health care operations. For uses beyond that, we will ordinarily obtain your written authorization. The following offers more description and some examples of the potential uses and disclosures of your PHI:

Uses and Disclosures Relating to Treatment or Health Care Operations. We may disclose your PHI to doctors, nurses and other health care personnel who are involved in providing your health care. Your PHI may be shared with outside entities performing ancillary services to your treatment. Also, we may use and/or, disclose your PHI as may be reasonably necessary in the course of operating our medical help clinic. We may also send or communicate appointment reminders but subject to our normal confidentiality policies and any special instructions that you have given.

Uses and Disclosures for Which Special Authorization Will be Sought. For uses beyond treatment and operations purposes, we will ordinarily seek to obtain your authorization before disclosing your PHI. However, disclosure of your PHI may be made without your consent or authorization when required by law, when required for public health reasons, when necessary to avert a threat of harm to you or a third person, or when other circumstances may require or reasonably warrant such disclosure.

IV. **How You May Have Access to or Control of Your Protected Health Information.** The following is a description of the steps you may take to access or to otherwise control the disposition of your PHI:

To request restrictions on uses/disclosures: You may ask that we limit how we use or disclose your PHI. We will consider your request, but we are not legally bound to agree to the restriction. To the extent that we do agree to such restrictions, we will abide by such restrictions except in emergency situations. We cannot agree to limit uses/disclosures that are required by law.

To choose how we contact you: You may ask that we send you information at an alternative address or by alternative means. We will agree to your request so long as it is reasonably easy for us to do so.

To inspect and copy your PHI: Unless your access is restricted for clear and documented treatment reasons, you will be permitted to inspect your protected health information upon written request. We will respond to your request within 30 days. If we deny your request for access, we will give you written reasons for the denial. If you want copies of your PHI, we will make reasonable efforts to accommodate any such request. You may designate selected portions of your PHI for copying.

To request amendment of your PHI: If you believe that there is a mistake or missing information in our record of your PHI, you may request in writing that we correct or add to the record. We will respond within 60 days of receiving your request. Any denial will state the reasons for the denial. If we approve the request for amendment, we will change the PHI and so inform you. We will also inform any others who have a need to know about such changes.

To find out what disclosures have been made: You may request for us to provide you with a list of all disclosures of your PHI which we have made except for such disclosures as have been made in connection with your treatment, our health care operations, or as specifically required by law. We will respond to your request within 60 days of receiving it.

To receive this notice: You may receive a paper or electronic copy of this notice upon request.

V. **Acknowledgement:** I have reviewed this notice and ____accept or ____decline to receive a copy of this Notice:

Printed Name

Signature

Date