The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form are kept confidential. We are required by law to maintain the privacy of your protected healthcare information and to provide you with this notice of our legal duties and our privacy practices. HIPAA gives you the right to understand and control how y our protected health information (PHI) is used.

Under HIPAA regulations, we may use and disclose your Protected Health Information (PHI) without written consent for the following reasons.

Treatment: We may disclose PHI while providing coordinating or managing health care and related services by one or more healthcare providers. For example, communicating with your referring physician or with your pharmacy.

Payment: We may disclose PHI to obtain reimbursement for services, confirming coverage, billing or collections activities and utilization review. For example, we may need to verify your insurance coverage or send you a billing statement through a third-party vendor.

Health Care Operations: We may disclose PHI to conduce quality assessments or improvements during audits or evaluations of customer service or other reviews regarding practice operations. For example, we may need to contact you to remind you of an appointment or to request feedback about our service.

We may also be required to disclose your PHI for law enforcement, matters of public health and safety and other legitimate reasons. In all situations, we do our best to assure continued confidentiality to the extent possible.

We will not use your information for marketing or fundraising without your permission.

In compliance with federal and state privacy laws, written authorization by the patient or legal guardian is required before we can release records for any reason other than treatment, payment, or healthcare operations. If you give authorization to release your records, you may revoke such authorization in writing. We will honor your request from the date we receive your written request forward.

We will notify you if the privacy of your PHI has been compromised. Please let us know if you feel your protections have been violated by our office. You have the right to file a formal written complaint with our practice and with the Department of Health and Human Services, Office of Civil Rights.

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature and date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The Health Insurance Portability and Accountability Act (HIPAA) law allows for the use of information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous image in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? Y N

May we leave a message on your answering machine at home or on your cell phone? Y N

May we discuss your medical condition with any member of your family? Y N

If YES, please name the members allowed:

_____
_____
_____
_____

This consent signed by: (print name) _____

Signature: _____

Witness: _____