For the practice of _____

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

I, _____, acknowledge and agree to the following:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand that the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; or b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.

4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order obtain payment for my treatment, and as necessary for the Practice to conduct its specific health care operations.

5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

7. I understand that if I revoke this Consent at any time, the Practice has the right to refuse to treat me.

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the above information, and will accept full responsibility for asking any questions I may have.

_____ _____

Printed Name of Individual **Signature of Individual**

_____ _____

Signature of Legal Representative (e.g., Guardian, Parent, if a minor) **Relationship**

Date Signed_____ **Witness:**_____

NOTICE OF PRIVACY PRACTICES

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

The doctor(s) of this office are required by law to maintain the privacy and confidentiality of our patients' protected health information (PHI) and to provide them with notice of our legal duties and privacy practices with respect to the same.

Treatment: We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. For example, it may be necessary to seek consultation regarding your condition from other health care providers. Additionally, in the event of your primary health care provider's absence due to vacation, illness, or other emergency situation, it is our policy to refer to a substitute health care provider of our choice for assessment and/or treatment without advance notice.

Payment: We may disclose your health information and billing information to your insurance provider for the purpose of payment or health care operations. If you choose to pay for your health care services personally, we will, as a courtesy, provide an itemized statement to your insurance carrier for reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and medical codes which describe the health care services provided.

Workers' compensation: We may disclose your health information to comply with State Workers' Compensation Laws.

Emergencies: We may disclose your health information to notify, or assist in notifying, a family member or person responsible for your care about your medical condition in the event of an emergency.

Public Health: As required by law, we may disclose your health information to public health authorities for such purposes as preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting of domestic violence, reporting problems with products and reactions to medications to the Food and Drug Administration, and reporting disease or infection exposure.

Judicial and Administrative Proceedings: We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement: We may disclose your health information to a law enforcement official for such purposes as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons: In the event of your death, we may disclose your medical information to coroners or medical examiners.

Research: We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety: It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious or imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies: We may disclose your health information for military, national security or government benefits purposes.

Telephone Contact: It may be necessary for us to contact you by telephone to reschedule a missed appointment or for other reasons. If you are not at home, we will leave a message on your answering machine or with the person answering the phone. No personal health information will be disclosed other than the date and time of your scheduled appointment or a request to call our office.

Change of Ownership: In the event that our practice is sold or merged with another organization, your health records will become the property of the new owner.

YOUR HEALTH INFORMATION RIGHTS INCLUDE:

the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are not required to agree to the restriction you may request.
the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery.
the right to inspect and copy your health information.
the right to request that your protected health information be amended. However, we are not required to agree to amend your protected health information. If your request has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can challenge the denial.
the right to receive an accounting of disclosures of your protected health information from this office.
the right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to Notice of Privacy Practices

We reserve the right to amend this notice at any time. Until such amendment is made, our office is required by law to comply with this notice.

We are required by law to maintain the privacy of your health information and to provide you with notice of legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact our office at (760) 744-1881. If necessary, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints

Complaints about your Privacy rights or the handling of your health information should be directed to this office at (760) 744-1881. If necessary, you may make an appointment for a personal conference in person or by telephone within 2 working days. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509 F HHH Building
Washington, DC 20201