NOTICE OF PRIVACY PRACTICES

Under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), Public law 104-191, published December 28, 2000, by the US Department of Health and Human Services, we are required to notify you of our use of your Protected Health Information (PHI).

This law allows this clinic to collect and use PHI from you for the use of health care purposed only. **Health care purposes only refers to normal release of practitioner's notes and/or examination findings to insurance companies authorized to reimburse this clinic for incurred charges by the patient named below or signed by their representative as stated below.** This clinic will ensure that health information is not used for non-health purposes. PHI will be disclosed only for the purpose of health care treatment, payment and operations as allowed by HIPPA. Any non-routine disclosure of your PHI will be prohibited without signed, informed consent by yourself agreeing to such disclosure.

By signing below, I understand my rights under HIPPA and authorize the release of my PHI for routine health care treatment, payment and operations. I understand I have the right to inspect, get copies, and request amendments be made to my file at any time. I also have the right to request information from this clinic by alternative means. Any non-routine disclosures must be authorized by myself via a signed consent. I understand that I have the right to complain to this clinic's directly, or to file a formal complaint to the Secretary of the Department of Health & Human Services if I feel my PHI rights have been violated. I understand that these privacy policies may change in the future.

Patient's Printed Name: ________________________________

Patient's Signature: __________________________________

Date Signed: ____

Witness Signature: ___________________________________

Date Signed: ____