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NOTICE OF PRIVACY PRACTICES AND CONSENT FORM

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties and your rights concerning your health information. Before we begin any health care treatment we must require you to read and sign this consent form stating that you understand and agree with how your records will be used.

1. The patient understands and agrees to allow this Internal Medicine/Pediatric office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care. As an example, the patient agrees to allow this office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companiesrequire for payment.

2. We may use or disclose your health information to your attending and referring physician.

3. The patient has the right to examine and obtain a copy of his/her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

4. A patient's written consent need only be obtained one time for all subsequent care given in this office.

5. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for any care given prior to the request to revoke consent, but would apply for any treatment given after the request has been received.

6. As stated in #3 we must disclose your health information to you. We may also disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or payment for your healthcare, unless you request that we not do so. Patients 18 years and older will be considered as an adult and will be responsible for making their own decisions.

7. We may use or disclose your health information to provide you with appointment reminders, such as voicemail messages or letters.

8. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

9. Patients have the right to file a formal complaint with our privacy official about any possible violations of their policies and procedures.

10. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the office has the right to refuse treatment.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

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PATIENT OR LEGAL GUARDIAN SIGNATURE **DATE**