NOTICE OF PRIVACY PRACTICES --- SUMMARY AND ACKNOWLEDGEMENT

We will use and disclose your health information in order to:

1. Treat you or to assist other health care providers in treating you
2. Obtain payment for our services and to a1low insurance companies process claims for services rendered to you
3. Comply with quality assessments and licensing requirements

Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization. However, in the following circumstances, we may disclose your health information without your written authorization:

1. To family members or care takers who are involved in your health care
2. For purposes of public health and safety
3. To government agencies and health insurance companies for purposes of their audits, investigations, and other oversight activities
4. To government authorities to prevent child abuse or domestic violence
5. To the FDA to report product defects or incidents
6. To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders
7. When required by court orders, search warrants, subpoenas, and as otherwise required by law

This information may be submitted by the following methods: U. S. Postal Service and similar delivery services, facsimile, Internet, voice mail, telephone, and/or personal communications.

The most common types of entities to whom we typically provide personal health-related information are: physicians outside of this practice, medical facilities (i.e. hospitals, nursing homes), laboratories for medical tests, pharmacies, insurance companies, state and federal agencies.

Occasionally, we may mail patient forms and surgery information to you. Additionally, we will mail account statements to you. We may need to contact you by telephone to confirm or change appointments, discuss treatment, ask about referrals or discuss account balances. If we cannot reach you at home and need to call you at work, we will only leave a message for you to return our call. So we can ensure that this information gets directly to you, please be sure to inform us of any address or telephone number changes.

PATIENT RIGHTS:

1. To have access to and/or a copy of your health information
2. To receive an accounting of certain disc1osurs we' have made of your health information
3. To request restrictions as to how your health information is used or disclosed
4. To request that we communicate with you in confidence
5. To request that we amend your health information
6. To receive notice of our privacy practices

If you have a question, concern, or complaint regarding; our privacy practices or you wish to have more information, please request a copy of the Notice of Privacy Practices.

If you would like copies of your medical records and/or information sent to another physician, medical facility, your life insurance carrier, disability insurer, or other entity, you must authorize the release of this information in writing. We can provide you with the necessary form.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

I acknowledge that I was provided a copy of the Notice of Privacy Practices Summary and was offered a complete copy of the Notice of Privacy Practices.

Patient Name (Please Print):____

Signature: ____

DATE: ____

Parent or Authorized Representative (if applicable): ________________________________

DATE: ______________________________________