NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED

HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE

REVIEW IT CAREFULLY AND SIGN THE ACKNOWLGEMENT BELOW.

Summary:

By law, we are required to provide you with our Notice of Privacy Practices. This notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. The right to inspect and copy your information.
2. The right to request corrections to your information.
3. The right to request that your information be restricted.
4. The right to request confidential communications.
5. The right to a report of disclosures of your information.
6. The right to a paper copy of this notice.

We want to assure you that your Medical/Protected health information is secure with us. This notice contains information about how we will insure that your information remains private.

Acknowledgment of Notice of Privacy Practices

I acknowledge that I have read and understand, this Notice of Privacy Practices.

_____ _____

Patient Name or Legal Guardian Date

_____

Signature

Updated 8/2016