

Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

At this office, we always keep your health information secure and confidential. Law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment, for example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.

We may use your information to contact you either by phone or with a reminder card in the mail to remind you of an upcoming appointment. If you are not home, we may leave a message on voice mail or with a person who may answer the phone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your healthcare information when required by law.

If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without prior written authorization.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

As we will need to contact you from time to time, we will use whatever address or phone number you prefer.

You have the right of access to and the right to have copies of your records. We may charge a reasonable fee for the copies.

You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to make the amendment or change, we will not remove or alter earlier documents, but will add new information.

You have a right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of this change in writing.

You may file a complaint to the Department of Health and Human Services, 200 Independence Ave., SW, Room 509F, Washington, D.C. 20201. You will not be retaliated against for filing a complaint.

However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Private Officer Faith Grove at (707) 569-9706.

Acknowledgement

I understand and have read this Notice of Privacy Practices.

Dated _____ Signed _____

Printed Name _____

If signing as a parent or guardian, please note the name of the patient
