NOTICE OF PROTECTED HEALTH INFORMATION PRACTICE

The regulations established under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, published December 28, 2000 by the US Department of Health and Human Services requires that this clinic notifies you of your 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 purposes only. Health care purposes only refers to the normal release of doctor's notes and/or examination findings to the insurance companies authorized to reimburse this clinic for incurred charges by the patient named below or signed by the 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 HIPAA. 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 HIPAA 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 to be made to my file at anytime. I also have the right to request to receive information from this clinic by alternative mans. Any non-routine disclosures must be authorized by me via a signed consent. I understand that I have the right to file a formal complaint to the Secretary of the Department of Health and Human Services if I feel my PHI rights have been violated. I understand that these privacy policies may change in the future.

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Patient's **Printed** Name Date

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Patient or Patient Representative's Signature Date

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Witness Signature and date Date