



Notice of Privacy Practice

This notice describe privacy matters about your Health information and we are required by law to give you this notice.

We must have your written, signed Consent to use and disclose health information for the following purpose:

- FOR TREATMENT. We may need to disclose Health information about you to Doctors, Nurses, Technicians, office staff or other personnel who are involved in your health care.
- FOR PAYMENT. We may need to use and disclose your health information so that treatment and services at this office may be billed to and payment collected from you, an insurance company or third party.
- FOR HEALTH CARE OPERATION. We may need to use and disclose health information about you to be sure you are receiving the highest quality of care.
- APPOINTMENT REMINDERS. We may need to contact you as a reminder that you have an appointment at this office.
- TREATMENT ALTERNATIVES. We may need to tell you about other treatment alternatives.
- HEALTH RELATED PRODUCTS AND SERVICES. We may need to tell you about other products and services available.

We may use and disclose health information about you for the following purposes, subject to applicable legal requirements and limitations:

- TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY
- IF REQUIRED BY FEDERAL STATES OR LOCAL LAW
- FOR RESEARCH PROVIDED PERSONAL INFORMATION, SUCH AS NAME IS NOT GIVEN
- ORGAN OR TISSUE DONATION, IF YOU ARE A DONOR
- FOR MILITARY, VETERANS, NATIONAL SECURITY AND INTELLIGENCE, IF REQUIRED BY THESE AUTHORITIES
- WORKERS' COMPENSATION
- PUBLIC HEALTH RISK
- HEALTH OVERSIGHT ACTIVITIES , SUCH AS STATE OR FEDERAL HEALTH AGENCIES
- LAWSUITS AND DISPUTES OR IN RESPONSE TO SUBPOENA
- LAW ENFORCEMENT IN RESPONSE TO A COURT ORDER
- CORONERS, MEDICAL EXAMINERS AND FUNERAL DIRECTORS
- HEALTH INFORMATION THAT DOES NOT PERSONALLY IDENTIFY YOU
- FAMILY AND FRIENDS WITH YOUR VERBAL CONSENT

You have the right to inspect and copy your health information. We may however request a fee for copying medical files.

You have the right to amend your medical file if you believe the information is incorrect. You may need to fill our and sign Medical Record Amendment form.

You have a right to a paper copy of this notice if desired by you.

You have the right to an accounting of disclose provided it is not related to treatment, healthcare operations or payment. You must submit this request in writing and include a time period not longer than 6 years.

You have a right to request restrictions or limitations of your health information. We are not required to agree with your request. If we do agree, we will comply with your request unless the information is needed to provide your emergency treatment.

If you believe your privacy right has been violated, you may file a complaint with our office.