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Description automatically generated**PATIENT PRIVACY NOTICE**

The Department of Health and Human Services has established a “Privacy Rule” to help ensure that personal health care records are protected. This rule, also known as HIPAA, was also created to provide standards for health care providers to obtain their patients’ consent for uses and disclosures of health information about the patient to carry out treatment, payment, and/or health care operations.

As our patient we want you to know that we respect the privacy of your personal

Medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel need your health care information, information about treatment, payment, or health care operations, to provide care that is in your best interest. We also want you to know that we support your full access to your personal medical records.

You may refuse to consent to the use or disclosure of your Personal Health Information (PHI), but this must be in writing. Under this law, we have the right to refuse to treat you should you refuse to disclose your personal health information. If you choose to give consent in this document, at some future time you may submit a written request to refuse disclosure of all or part of your PHI, it will become effective the date the written notice was received. You may not revoke actions that have already been taken with regarding your PHI, which relied on this previously signed consent. Please note that there are certain medical facilities that we deal with that are not required to obtain patient consent.

You have the right to review our privacy notice in its entirety, to request restrictions, and revoke consent in writing after you have reviewed our privacy notice. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

Below, please list family members or friends who we may discuss your PHI (such as office appointments, questions about your care, or insurance issues that may arise)

Name: Relationship:

Name: Relationship:

Print your name: DOB:

Signature: Date:

Witness: Date: