Authorization for the Use or Disclosure of Protected Health Information

This is a summary of our Notice of Privacy Practices. The entire text detailing our privacy practices is available for your review, and we encourage you to read it and ask any questions you may have regarding our privacy practices. If you have any questions or would like to exercise any of your rights, please contact our Privacy Officer. After reviewing the materials, please sign in the space provided below.

PATIENT RIGHTS

As a patient, you have a right to inspect, copy, amend, request a restriction or revoke a prior restriction on the use and disclosure of your Protected Health Information (PHI). You may also request a copy of any accounting of disclosures, which will detail all disclosures made for reasons other than treatment, payment, or health care operational purposes. You may request that we communicate with you only in a specific manner (i.e. "only communicate with me at my work telephone number").

PROVIDER RIGHTS

As your health care provider, we can use or disclose your PHI for treatment, payment, or health care operational purposes. Any other disclosure requires you to sign a specific authorization.

_____ _____

Patient (or Guardian) Signature Date

_____ _____

Patient Name (printed) Date of Birth

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