

NOTICE OF PRIVACY

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

We have always kept your health information secure and confidential. An act requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The act 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 our service. 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 computers.

We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointment. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

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 health information when required by law.

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

This practice will not otherwise use, sell or disclose your health information.

Acknowledgment

I have received a copy of this office's Notice of Privacy Practice.

Date: _____

Signed: _____

Print Name: _____

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

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.

As we will need to contact you from time to time, we will use the address or telephone number you prefer. You have the right to transfer copies of your health information to another practice. We will mail your files for you. You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you 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 changes to your request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove or alter earlier documents, but will add new information.

You have the right to review a copy of this notice. If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding the privacy of your health information, please contact our Privacy Officer at (760) 642-0711.

This notice has been in effect as of April 14, 2003.