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PRIVACY STATEMENT AND PATIENT AUTHORIZATION FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION

The above named doctor, have informed me by this document that certain policies are in effect in this office, to insure my right of privacy to confidentiality of my personal health information. The doctor has informed me that this letter will cover the elements required in the HIPPA (Health Information Privacy Protection Act of 1996) regulations that go into effect April 14, 2003. My signature below signifies that I have received this document and understand the intent and content of it. That it protects my rights to privacy, my ability to inspect and change any conditions of health information disclosure at any time by requesting an addendum to the chart but not the removal of any part of the chart. The addendum is to be completed in the presence of the doctor or of designated office personal.

The doctor is a provider of record and is responsible for maintaining my health record and confidentiality at all times. The office staff, including administrative and ancillary medical attendants have been counseled and trained in regards to the confidentiality of my medical record, and will not discuss my care, nor have access to confidential information that is not required for them to perform their duties. Their duties require filing of reports within the chart, maintaining records, securing records, communication with insurance companies and governmental agencies. They are to be discrete and avoid incidental disclosure as best as physically possible within the confines of the office.

My signature below further authorizes the doctor and his staff to release pertinent health information for routine purposes such as treatment, communication with consultants and other health care providers necessary to adequately provide for my complete healthcare, and payment by third party payers. This applies to all forms of communication, either paper of electronic. "Minimal disclosure" of information will be permitted sufficient to comply with results from employers and to process workmen's compensations claims. Governmental agencies including the health department may be notified in reporting disease conditions required by state law.

On proper signing of an authorization to release information, I consent to have the doctor release to me or any individual agency I designate, or to my next of kin, if I am mentally or physically incapacitated to give my permission, a copy of my medical record in part or whole. I acknowledge that there will be a charge for such copying of the chart as prescribed by law and that the copy will be available within 10 working days.

I have had the opportunity to ask questions. I acknowledge that at any time I may change any and all restrictions herein about sharing my health information. I give the doctor and his staff permission to utilize my protected information as described above in order to conduct their business and provide for my necessary medical care. This document shall remain in effect unless I direct otherwise.

PATIENT NAME:

_____

SIGNED:

_____

DATE: _____