THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUAL IDENTIFIABLE HEALTH INFORMATION.

A required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA)

Our practice is dedicated to maintaining the privacy of your individual identifiable health information, whether electronically, by paper or by oral communication. The new HIPPA law gives you as the patient the right to understand and control how your health information is being used. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY INDENTIFIALBLE HEALTH INFORMATION IN THE FOLLOWING WAYS:

1. Treatment

2. Payment

3. Health Care Operations

THERE ARE ADDITIONAL USES AND DISCLOSERS OF INDIVIDUAL IDENTIFIABLE HEALTH INFORMATION, IN WHICH ARE POSTED WITHIN THE OFFICE. YOU ALSO HAVE THE RIGHT TO REQUEST A PAPER COPY OF THIS NOTICE FROM US UPON YOUR REQUEST.

YOUR RIGHTS REGARDING YOUR INDIVIDUAL INDENTIFIABLE HEALTH INFORMATION

1. Confidential Communications

2. Requesting Restrictions

3. Inspection and Copies

4. Amendment

5. Accounting of Disclosures

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Patients Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and how the individual will obtain a revised notice upon request.

If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services.

For more information about HIPPA or to file a complaint contact:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Ave, S.W.
Washington, DC 20201
(202) 619-0257
Toll Free: 1-877-696-6775

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I,_____, reviewed and understand my privacy rights as stated under the

Patient Privacy Practice.

_____ _____
Signature of Patient Date

_____ _____ / _____ _____ / _____ _____ / _____ _____
Initial Date Initial Date Initial Date Initial Date