NOTICE OF PRIVACY PRACTICES

This notice describes how medical protected health information about you may be used and disclosed and how you can get access to this information.

Disclosure of your health information is limited to the minimum necessary for the purpose of disclosure. This provision does not apply to the transfer of medical records for treatment.

With a written request you may inspect and receive copies of your records within 30 days of the request. There may be a reasonable cost-based fee for preparation, photocopying, and postage.

You may request changes to your records, which this practice has the right to accept or deny.

We maintain a history of protected health information that is accessible to you.

By checking the lines below I authorize being contacted for appointment reminders, announcements, and to inform you about our practice.

_____ Mail
_____ Email at _____
_____ Voice mail
_____ Text message – Carrier _____
_____ Telephone number_____

Acknowledgement of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand this form will be placed in my patient chart and maintained for 6 years.

Our practice is required to abide by this notice. Any revisions will be prominently displayed in a clearly visible location in our office.

_____
(Patient Name Printed)

_____ _____
(Patient Signature) Effective Date of this Notice

If you have any questions about this notice, the name and phone number of our contact person is listed below.
Contact person Dr. Shawn Snow
Office number 386 424 9977

Revised 03/13/2018