PATIENT RIGHTS

FOR LAW ENFORCEMENT
As defined or required by State or Federal law we may disclose your health information to a law enforcement official for certain law enforcement purposes including, certain limited circumstances, if you are a victim of a crime, or in order to report a crime.

FAMILY, FRIENDS and CAREGIVERS
We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

AUTHORIZATION to USE or DISCLOSE HEALTH INFORMATION
Federal, State or Local law requires us to not disclose your health information without your written authorization. You may revoke the authorization in writing at any time.

RESTRICTIONS
You have the right to request restrictions on certain uses and disclosers of your health information.

CONFIDENTIAL COMMUNICATION
You have the right to request that we communicate with you in a certain way. You may request that the communication is done privately. You may request that that no others receive information.

AMEND YOUR HEALTH INFORMATION
You have the right to ask us to update or modify your records if you believe your health records are incomplete or incorrect. In order to standardize our process, please provide us with your request in writing and your reason for the change. Your request may be denied if the health information record in question was not created by our office.

REQUEST A COPY OF THIS NOTICE
You have the right to request a copy of this notice. To request a copy please stop by or call and we will send you a copy.

REQUEST A COPY OF YOUR RECORDS
You have the right to request a copy of your medical records either for personal use or because your transferring to a different doctor. You will need to sign a medical release form and a fee will be required upon asking for your record.

Signature of Patient (if over 18 years) or Parent or Guardian

____Date_______________

Please Print Name of Patient ____