

## **NOTICE OF PRIVACY PRACTICES**

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

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

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### **OUR LEGAL DUTY:**

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this notice while in effect. This notice took effect 10/15/2002, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms in our notice effective for all health information that we maintain, including health information that we created or received before the changes were made. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request. You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the contact information listed in this notice.

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### **USES AND DISCLOSURES OF HEALTH INFORMATION:**

We use and disclose health information about you for your treatment, payment, and healthcare operations. For example...

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain for services we provided to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations.

Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

**Your authorization:** In addition to our use of your health information for treatment, payment, and healthcare operations, you may give us written authorization to use your health information or disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any uses or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the patient right of this notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment of your healthcare, but only if you agree that we may do so.

**Persons Involved in Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or other person responsible for your care, your location, your general condition or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses and disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences about your best interest allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required By Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health and safety of others.

## **CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION**

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### **Section A: Patient Giving Consent**

Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

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### **Section B: To The Patient – Please Read The Following Statements Carefully**

**Purpose Of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out our treatment, payment activities, and healthcare operations.

**Notice Of Privacy Practices:** You have the right to read our Notice Of Privacy Practices before you decide whether or not to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, and our uses and disclosures of your protected health information, and of other important matters about your protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice Of Privacy Practices. If we change our privacy practices, we will issue a revised Notice Of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

**You may obtain a copy of our Notice Of Privacy Practices, including any revisions of our notice, at any time by contacting Dr. Nancy Pruett, Amanda Pruett, or Heather Cowger at (317)284-1850.**

**Right To Revoke:** You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to either contact person listed above. Please understand that revocation of this consent will not affect any action we took in reliance to this consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this consent.

### **Signature:**

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this consent form and your Notice Of Privacy Practices. I understand that by signing this consent form, I am giving Dr. Nancy K. Pruett and her staff my consent to the use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**If this consent is signed by a personal representative on behalf of the patient, please complete the following:**

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

\*You May Refuse To Sign This Form\*

I, \_\_\_\_\_, have received a copy of the Notice Of Privacy Practices.

Please Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

For Office Use Only

\_\_\_\_\_  
\_\_\_\_\_

We attempted to obtain written acknowledgement of receipt of our Notice Of Privacy Practices, but the acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining the acknowledgement
- Other (please specify)

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