Summary of Notice of Privacy Practices

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) I have certain rights to privacy regarding my protected health information (PHI). I understand this information will be used to:

1. Direct my treatment and follow up possibly among multiple healthcare providers who may be involved in my treatment both directly and indirectly.
2. Obtain payment for services rendered.
3. Conduct normal practice of operations.

I also have rights with respect to my PHI:

1. The right to inspect and copy my information
2. The right to amend my information
3. The right to an accounting of my disclosures
4. The right to request restriction to those disclosures
5. The right to confidential communications
6. The right to file a complaint if I feel my rights have been violated

SFH may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carring out treatment, payment and healthcare options (TPO), such as appointment reminders, insurance items and all any pertaining to my clinical care, including laboratory results among others.

SFH may mail to my home or other designated location any items that assist the practice in carrying out TPO such as appointment reminders, patient statements or requests to contact the office.

I have the right to request that SFH restrict how it uses or discloses my Protected Health Information (PHI) to carry out TPO. However, the practice is not required to agree to my requested restrictions, but is bound by this agreement if it does.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If signed consent is refused, SFH may decline to provide treatment.

By my signature below, I agree I have been informed of SFH's Notice of Privacy Practices, understand this is a summary of these practices and have had time to review the entire Notice of Privacy Practices prior to signing. I also understand that I can request of copy of same. I understand that SFH has the right to change its privacy practices and will post any changes.

_____ _____

Printed Patient Name Date

_____

Patient Signature