# HIPAA Consent

This notice **describes how medical information about you may be used and disclosed** and how you can get access to this information. Please review it carefully.

We are committed to protecting the privacy of our patients' personal and health information. All of our employees are required to sign confidentiality agreements and are required to comply with our confidentiality policy.

We may use or disclose your protected health information for purpose of treatment, payment, or practice operations only with your written consent. For example, we may contact another physician to coordinate your care, submit a claim to an insurer, or look at your file to perform internal quality monitoring. We must obtain your written authorization at any time in writing. This will not apply to information used or disclosed while the consent or authorization is in effect.

We will provide access to your information, without your cone tor authorization, when required to do so by law or regulation. Access may be granted to public health and law enforcement authorities, health care oversight agencies, government benefit programs, employers (in cases of work-related illness or injury), courts, and administrative tribunals.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services. You may want a friend or family member to discuss care with a physician(s), or a staff member, take messages, and pick up prescriptions or other medically related communications.

- **Please indicate if there is a friend or family member to whom we are allowed to release medical information to:**

Name:______________ Phone____________________ Relationship____________

Name:______________ Phone____________________ Relationship____________

You may also identify a friend or family member who whom we are specifically restricted from releasing medical information to:

Name:______________ Phone____________________ Relationship____________

You have the right to: access and amend your information, request an accounting of any disclosures, request restrictions on use and disclosure of your information, request of copy of this Notice, or receive confidential communications. If you request restrictions on the use and disclosure of your information, we are not required to grant your request. You may exercise your rights by contacting the individual identified at the conclusion of this notice.

We are required by law to maintain the privacy of protected health information and to provide you ith notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of the most current notice in effect. We reserve the right to change the terms of our notice and to make the new notice provisions effective for all protected health information that we maintain. We will provide you with a revised notice by mail.

If you believe that your privacy rights have been violated, you may complain to us or to the Secretary of the U.S Department of Health and Human Resources. We will not retaliate against you for filing a complaint.

For more information, please contact us at: 313-908-9374 This notice is effective:2/29/12

**The undersigned acknowledges that he/she has received a copy of this notice of privacy practices.**

________________________________ ___________________________

Signature Date