NOTICE OF PRIVACY PRACTICES

Your patient rights

*You may request a copy of this notice and we will provide one to you.
*You may request in writing that we communicate your health information by alternative means such as email or fax or to alternative locations.
*You have a right to copies of your own health information. Your request must be submitted in writing to our HIPAA Compliance Officer either by mail or in person. We will let you know if any copying fees will be assessed. If there are copying fees, those fees will not exceed that which is allowable by the TSBDE rules and regulations.
*You may request that we implement additional restrictions on the use and disclosure of your private health information and we will determine whether or not the request is feasible.
*You may request that we amend your health information. This request must be in writing along with an explanation for the needed amendment. Keep in mind that we may deny your request but will maintain a copy of your request in your patient file.
*You are entitled to a list of occurrences in which we or our business associates have disclosed your private health information for reasons other than for treatment, payment, or healthcare operations for the past 6 years. Submit your request in writing.

Uses and Disclosures of your Private Health Information

*To yourself
*To family and/or friends that you authorize for the purposes of helping with your healthcare or for payment of services.
*To obtain payment
*To other healthcare providers involved in your care
*To notify your family or representative about your care and health status as needed.
*To cooperate with law enforcement for reasons not limited to but including abuse, neglect, domestic violence, or crime victim.
*To military authorities if you are personnel of the Armed Forces and the information is needed for lawful intelligence, counterintelligence, or other national security purpose.
*To correctional institutions if you are an inmate.
*To facilitate our own quality assessments and improvements, reviewing competence of healthcare professionals, evaluation of practical performance, training programs, accreditation, certifications, licensing, or credentialing activities.
*To provide you with appointment reminders such as voicemail or mailers.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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:

Contact Officer: Charlene Ouzts
Telephone: 903-759-4607 Fax: 903-759-3626
Address: 1201 Pine Tree Rd, Longview, TX 75604

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 the contact person listed above. Please understand that revocation of the Consent will not affect any action we took in reliance on the Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

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 my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:_____Date:_____
If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:_____

Relationship to Patient:_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOUSIGN IT
Include completed Consent in the patient's chart