



# The Pain & Brain Healing Center

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## Privacy Practices

THIS FORM IS REQUIRED BY LAW AND SERVES TO PROTECT YOUR RIGHT TO PRIVACY. **Pain & Brain Healing Center** protects the privacy of your personal and health information. Personal and health information includes both medical information and individually identifiable information, such as your name, address, or telephone number. **Pain & Brain Healing Center** will not disclose this information without your authorization, except as permitted by law. Our **Notice of Privacy Practices** provides information about how your protected health information may be used or disclosed. You have the right to request that we restrict how protected health information about you is used or disclosed. Please review the Notice of Privacy Practices below before signing this consent.

By signing this form, you consent to our use and disclosure of your protected health information as indicated in the Notice of Privacy Practices. Please note that your personal information is **not** shared with third parties such as financial, credit, or marketing companies. Use is restricted to procedures that are relevant to your care. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

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Print name

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Signature Date

### Effective Date: April, 2009

Please Note: In order to comply with the numerous state, Federal, and local laws that govern medical information privacy, this document is provided. **Pain & Brain Healing Center**, its healthcare practitioners, and all associated personnel will do everything possible to maintain the privacy of your medical information as required by law. Under no circumstances will **Pain & Brain Healing Center** disclose your personal or medical information to any outside parties.

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.

### WHO WILL FOLLOW THIS NOTICE.

This notice describes **Pain & Brain Healing Center** practices and that of:

- Any health care professional authorized to enter information into your patient chart.
- All employees, staff and other clinic personnel.

### OUR PLEDGE REGARDING MEDICAL INFORMATION:

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at the clinic. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the clinic, whether made by clinic personnel or your personal doctor. This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

## **We Are Required By Law To:**

- Make sure that medical information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to medical information about you; and follow the terms of the notice that is currently in effect.

## **HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.**

The following categories describe different ways that we use and disclose medical information.

**For Treatment:** Medical information about you is utilized to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, or other clinic personnel who are involved in taking care of you, medical information shared about you in order to coordinate the different things you need, such as lab work and x-rays. We may use and disclose medical information about you for clinic operations. These uses and disclosures are necessary to run the clinic and make sure that all of our patients receive quality care.

**Appointment Reminders:** We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at the clinic.

**Treatment Alternatives:** We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

**Health-Related Benefits and Services:** We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

**Individuals Involved in Your Care or Payment for Your Care:** We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

## **As Required By Law We will disclose medical information about you when required to do so by federal, state or local law.**

**You have the Right to Inspect and Copy Your Records.** If you request a copy of the information, fee for the costs of copying, mailing or other supplies associated with your request may be charged.

**You Have the Right to Amend Your Records,** if you feel that medical information we have about you is incorrect or incomplete, as long as the information is kept by or for the clinic. Your request must be made in writing. In addition, you must provide a reason that supports your request. We will deny requests to amend information that was not created by us.

**Right to an Accounting of Disclosures:** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you; this request must be submitted in writing.

**Right to Request Restrictions:** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the address below. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

## **We Reserve the Right to Change This Notice**