

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you and/or your child (“You”) may be used and disclosed and how you can get access to this information.

Our Commitment to Protect Your Privacy

We are committed to protecting the privacy of your medical information. Your care and treatment is recorded in a medical record. So that we can best meet your medical needs, we share your medical records with the healthcare providers involved in your care. Including those providers on your treatment team. We share your information only to the extent necessary to help you get insurance reimbursement, to conduct our business operations, and to comply with the laws that govern healthcare. We will not use or disclose your information for any other purpose without your permission.

You Have the Following Rights Regarding Your Medical Information:

- To inspect/obtain a copy of your medical records, subject to certain exceptions.
- To add an addendum or correction to your medical record.
- To request restrictions on certain uses/disclosures of your medical information.

We May Use and Disclose Your Medical Information for the Following Purposes:

- To provide you with medical treatment and services.
- To help you receive reimbursement from your insurance company.
- For functions necessary to run our practice and assure that our patients receive quality care.
- As required by law.

There Are Additional Situations Where We May Disclose Your Medical Information Without Your Authorization. Such as:

- For public health activities (e.g., reporting abuse or reactions to medications).
- To a health oversight agency, such as the California Department of Health Services.
- In response to a court or administrative order, subpoena, warrant or similar process.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of our *Notice of Privacy Practices*. Our *Notice of Privacy Practices* provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full *Notice of Privacy Practices*. If you have any questions about our *Notice of Privacy Practices*, please ask Dr. Carlton.

Acknowledgement of Receipt: I acknowledge receipt of the *Notice of Privacy Practices* as provided by the office of Pamela Carlton, M.D.

Signature: _____ Date: _____
Patient, Parent or Legal Guardian

Relationship to patient: _____

Patient's Name _____ Patient's Date of Birth _____