NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

USES AND DISCLOSURES—PLEASE READ THIS IN ITS ENTIREITY AND CAREFULLY

TREATMENT. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

PAYMENT. Your health information may be used to seek payment from your health plan, from other sources or coverage such as an automobile insurer or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on days of service, the services provided and the medical condition being treated. You are required to provide this practice with all-insurance coverage information, health, auto and workers compensation (if applicable), or discuss and provide an alternative method for providing payment for services to this practice.

HEALTH CARE OPERATIONS. Your health information may be used as necessary to support the day-to-day activities and management of this practice, **ATLANTIC ORTHOPAEDICS, P.A.** For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

LAW ENFORCEMENT. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections to facilitate law-enforcement investigations and to comply with government mandated reporting.

PUBLIC HEALTH REPORTING. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's health department.

OTHER USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

ADDITIONAL USES OF INFORMATION

APPOINTMENT REMINDERS. Your health information will be used by our staff to send you appointment reminders.

INFORMATION ABOUT TREATMENTS. Your health information may be used to send your information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and service that we believe may interest or be a benefit to you.

INDIVIDUAL RIGHTS

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections of your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

THE DUTIES OF THIS MEDICAL PRACTICE KNOWN AS ATLANTIC ORTHOPAEDICS, P.A.

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices that are outlined in this notice.

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our polices and practices may be required by changes in federal and state law and regulations. Whatever the reason for the revisions, we will provide you with a revised notice on your next visit. The revised polices and practices will be applied to all protected health information that we maintain.

REQUEST TO INSPECT INFORMATION. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access by asking our receptionist or contacting the Privacy Officer in writing.

COMPLAINTS. If you would like to submit a comment or complaint about our privacy practices, or suspect violation, you can do so by letter, outlining your concerns. Please address this correspondence to The Privacy Officer care of this medical practice at our current address.

THE EFFECTIVE DATE OF THIS NOTICE – OCTOBER 16, 2002

CONSENT TO USE AND DISCLOSE PROTECTED INFORMATION

Your protected health information will be used by this practice, known as **ATLANTIC ORTHOPAEDICS, P.A.** or disclosed to others for the purposes of treatment, obtaining payment or supporting the day-to-day health care operations of the practice.

We are providing you with a copy of our Notice of Privacy Practices. We request that you review the notice prior to signing this consent.

You may request a restriction on the use or disclosure of your protected health information. If you should wish to restrict your disclosure, you should make the request in writing.

This practice however, may or may not agree to restrict the disclosure of your protected health information.

If we agree to your request, the restriction will be binding. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of federal privacy standards.

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date of your revocation of consent is received will not be affected.

This practice reserves the right to modify the privacy practices outlined in the notice.

SIGNATURE

I have reviewed this consent form and have reviewed the Notice of Privacy Practices. I give my permission to this practice to use and disclose my health information in accordance with it.

_____

Name of Patient (Print Clearly)

_____

Signature of Patient

_____

Date

_____

Signature of Patient Representative

_____

Relationship of Patient Representative to Patient