HIPPA NOTICE OF PRIVACY PRACTICES

We are committed to preserving the privacy of your personal health information (PHI). In fact, we are required by law to protect the privacy of your medical information.

We may require your written consent before we use or disclose to others your PHI for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

- **Treatment** includes activities performed by a health care provider, nurse, office staff, and other types of health care professionals providing care to you, coordination or managing your care with third parties, and consultations with and between other health care providers.

- **Payment** includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization. **I acknowledge and accept full responsibility for all charges made for all services rendered to me. I further acknowledge and agree that in the event my insurance fails to pay for services rendered, I am responsible for the unpaid amount.**

- **Health Care** Operations includes the necessary administrative and business functions of our office. I understand that diagnosis or treatment of me by Dr. Dennis Dewey, M.D. may be conditioned upon my consent as evidenced by my signature on this document. If Dr. Dennis Dewey, M.D. is requesting this authorization from you for our own use and disclosure or to allow another health care provider or health plan to disclose information to us:
  We cannot condition our provision of services or treatment to you on the receipt of this signed authorization.
  You may inspect a copy of the protected health information to be used or disclosed.
  Upon request, we can provide you with a copy of the signed authorization.

You have the right to revoke this authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in the reliance on this authorization.

You may review "Notices of Privacy Practices" for additional information about the uses and disclosures of information described in this consent prior to signing this consent.

If you have any questions, concerns or complaints about the Notice or your medical information, please contact Nancy of our office at 1895 Kingsley Ave. Suite 805, Orange Park, FL 32073, 904-276-2220.

Printed Patient Name _____ **Date** _____

Signature _____

Personal Representative _____