

Notice of Personal Health Information Practices (Privacy Notice)

This notice describes how information about you may be used and disclosed and how you can get access to this information when necessary. Please review it carefully.

Introduction:

At **Dr. David Bryman's office** we are committed to treating information about you and your health responsibly. This notice of health information practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protective health information. This notice is effective November 29, 2006, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record and Information:

Each time you visit **David Bryman, D.O.** a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as:

- A basis for planning your care and treatment,
- A means of communication among many health professionals who contribute to your care,
- A legal document describing the care you received,
- A means by which you a third party payer can verify that services were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights:

Although your health record is the physical property of Dr. Bryman the information belongs to you. You have the right to:

- Inspect and copy your health record,
- Amend your health record,
- Obtain an accounting of disclosures of your health information,
- Request a restriction on certain uses and disclosures of your information,
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities:

Dr. Bryman is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction,

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us, or if you agree, we will e-mail the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For more information or to Report a Problem:

If you have questions and would like additional information, you may contact us at 480-893-6728.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Patient Name: _____

Date: _____

By signing this form, you acknowledge that Dr. Bryman’s office has given you a copy of its Privacy Notice, which explains how your health information will be handled in various situations.

Check all that are true:

- I have received Dr. Bryman’s Privacy Notice.
- Dr. Bryman** has given me the chance to discuss my concerns and questions about the privacy of my health information.
- I have been given the opportunity to restrict disclosure of my information.

May we contact you via any of the following methods about appointments, treatment, billing, promotions or other matters relating to the program? (Please circle.)

Call you at home?	Yes	No	Leave a message at home?	Yes	No
Call you at work?	Yes	No	Leave a message at work?	Yes	No
Call you on your cell?	Yes	No	Leave a message on cell?	Yes	No
Send you e-mail at the address provided?			Yes	No	
Send mail to you at home to the address provided?			Yes	No	

If there are any individuals with whom we are permitted to share your medical information, please provide their name(s) here: _____

Patient’s Signature

Date

Office use only:

Complete if Acknowledgement Form is not signed:

Does patient have a copy of the Privacy Notice?

[] Yes [] No

Please explain why the patient was unable to sign an acknowledgement form and Dr. Bryman’s efforts in trying to obtain the patient’s signature:
