Notice of Privacy Practice
Dr. Bruce A. Smith

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.

This office may use and disclose medical and financial information related to your care that may be necessary now or in the future to:

- Facilitate payment by third parties for services rendered by us
- or to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation process.

Such information may be released to insurance companies, HMO and PPO’s, managed care organizations, IPA’s, Medicare/Medicaid, or other governmental or third party payors, or any organizations contracting with any of the above entities to perform such functions. Medical records may be delivered to a primary care physician or any other physician that is directly or indirectly responsible for your medical care or the payment thereof.

This office will not use or disclose any of your medical and financial information for any purpose not stated above without specific authorization. You, the patient, may revoke this authorization at any time.

You may request restrictions on certain uses and disclosures. This office is required to agree to a requested restriction. You have the right to receive confidential communications of your protected health information. You have the right to inspect, copy and amend your protected health information. You may also request an accounting disclosure of your protected health information from this office.

We are legally obligated to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information.

You may register a complaint with this office if you suspect that your privacy rights have been violated. We will investigate your complaint and inform you of the findings. This office will make no retaliation against you because you registered a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

You may speak to the Office Manager to obtain additional information regarding any questions you may have concerning this Notice or to or to receive a printed copy of this notice. This notice of Privacy Practices is effective as of April 14, 2003.

You have the right to request this office restrict uses and disclosures of your health information; however, this office is not required to agree to the requested restriction. You have the right to revoke this consent in writing, except to the extent that this office has previously taken action in reliance on this consent. Your treatment by this office is conditional upon you signing this consent.

If this consent is revised in the future you may obtain a revised copy from the Office Manager.

Rev. 12/2009
Acknowledgement of Receipt
Notice of Privacy Practices
For the office of
Bruce A. Smith, M.D.

Patient Name: ________________________________
Date: ________________________________________

I acknowledge that I have received and understand the Notice of Privacy Practices for this office.

Patient signature: ____________________________________________________________

Refusal to Sign
Notice of Privacy Practices
For the Office
Bruce A. Smith, M.D.

Patient Name: ________________________________
Date: ________________________________________

The above name person refused to sign receipt of their copy of the Notices of Privacy Practices for the following reason:

_______________________________________________________________________________
________________________________________________________________________________________
_______________________________________________________________________________________

Staff signature: ____________________________ Date: ________________

Revised 12/2009