NOTICE OF PRIVACY PRACTICES

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) I have certain rights to privacy regarding my protected health information. I understand that this information can be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand the *Notice of Privacy Practices* containing a more complete description of the uses and disclosure of my health information. I understand that this organization has the right to change this *Notice of Privacy Practices* from time to time and that I may contact the organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payments, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I give my permission for Dr. Furniss or his office personnel to discuss my treatment and/or

financial arrangements with: _____

Relationship: _____

Patient Name: _____

Signature: _____ Date: _____

Understanding the privacy of my health information, I hereby give Dr. Joshua K. Furniss and his staff permission to mail or e-mail any x-rays or information to a referring specialist who might assist in my treatment.

Patient Name: _____

Signature: _____ Date: _____