

Michael J. Polski, M.D.
NOTICE OF PRIVACY PRACTICES

We respect the privacy of your personal health information and are committed to maintaining our patients' confidentiality. This notice applies to all information and records related to your care that our facility has received or created. It extends to information received or created by our employees, staff, volunteers, and physician. This notice informs you about the possible uses and disclosures of your personal health information. It also describes your rights and our obligations regarding your personal health information.

1. We may use and disclose your personal health information for treatment, payment, and health care operations without needing to obtain your consent.
2. We may use and disclose personal health information about you for other specific purposes and to avert a serious threat to health or safety.
3. Your authorization is required for all other uses of personal health information.
4. Your rights regarding your personal health information:
 - You have the right to request restrictions on our use or disclosure of your personal health information for treatment, payment, or health care operations.
 - You have the right to request, either orally or in writing, your medical or billing records or other written information that may be used to make decisions about your care
 - You have the right to obtain a paper copy of this notice, even if you have agreed to receive this notice electronically. You may request a copy of this notice at any time.
 - You have the right to request that we communicate with you concerning personal health matters in a certain manner or at a certain location
5. We will promptly revise and distribute this notice whenever there is a material change to the uses or disclosures, your individual rights, our legal duties, or other privacy stated in this notice. We reserve the right to change this notice and to make the revised or new notice provisions effective for all personal health information already received and maintained by the clinic as well as for all personal health information we receive in the future. We will post a copy of the revised notice in the facility. In addition, we will provide a copy of the revised notice to all patients.
6. For further information you may contact our office at 817-297-1297.

ACKNOWLEDGEMENT

Name of Patient: _____

I acknowledge receipt of the patient's notice of privacy practices, delivered to me this _____ Day of _____, _____.

Signature

Date