

Mark Pirtle, DPT, CSCS, COMT - NOTICE OF INFORMATION PRACTICES

1. Mark Pirtle, DPT, CSCS, COMT may use and disclose protected health information for treatment, payment and healthcare operations. Examples of these include, but are not limited to, requested preschool, life insurance or sports physicals, referral to nursing homes, foster care homes, home health agencies and/or referral to other providers for treatment. Payment examples include, but are not limited to, insurance companies for claims including coordination of benefits with other insurers; collection agencies. Healthcare operations includes, but is not limited to, internal quality control and assurance including auditing of records.
2. Mark Pirtle, DPT, CSCS, COMT is permitted or required to use or disclose protected health information without the individuals written consent or authorization in certain circumstances. Two examples of such are for public health requirements or court orders.
3. Mark Pirtle, DPT, CSCS, COMT will not make any other use or disclosure of a patient's protected health information without the individual's written authorization. Such authorization may be revoked at any time. Revocation must be written.
4. Mark Pirtle, DPT, CSCS, COMT may at times contact the patient to provide appointment reminders or information regarding treatment alternatives or other health-related benefits and services that may be of interest to the individual patient.
5. Mark Pirtle, DPT, CSCS, COMT will abide by the terms of this notice or the notice currently in effect at the time of the disclosure.
6. Mark Pirtle, DPT, CSCS, COMT reserves the right to change the terms of its notice and to make new notice provisions effective for all protected health information that it maintains.
7. Mark Pirtle, DPT, CSCS, COMT will provide each patient with a copy of any revisions of it's Notice of Information Practice at the time of their next visit, or at their last known address if there is a need to use or disclose any protected health information of the patient. Copies may also be obtained at any time at our offices.
8. Any person/patient may file a complaint to the Practice and to the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with the practice, please contact Mark Pirtle, DPT, CSCS, COMT at the following phone number 520-795-3563. All complaints will be addressed and the results will be reported.
9. It is Mark Pirtle, DPT, CSCS, COMT's policy that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance of the privacy standards.
10. If you have questions regarding this form contact Mark Pirtle, DPT, CSCS, COMT at 520-795-3563.
11. The effective date of this notice is June 18, 2003.

I have read and understand the above. _____ Date: _____
Signature

**Consent to the Use and Disclosure of Health Information for Treatment, Payment or
Healthcare Operations and Acknowledgement of Receipt of Notice of Information
Practices**

I understand that as part of my healthcare, Mark Pirtle, DPT, CSCS, COMT originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
 - A means of communication among the many health professionals who contribute to my care
 - A source of information for applying my diagnosis and surgical information to my bill
 - A means by which a third party payer can verify that services billed were actually provided
 - And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.
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- I understand and have been provided with a *Notice of information Practices* that provides a more complete description of information uses and disclosures.
 - I understand that I have the right to review the notice prior to signing this consent.
 - I understand that the Practice reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided.
 - I understand that I have the right to object to the use of my health information for directory purposes.
 - I understand that I have the right to see and obtain copies of my medical record.
 - I understand that I have the right to request amendments be made to my medical record.
 - I understand that a six-year history of all disclosures will be accessible to me including the purpose of the disclosure and the address of the recipient.
 - I may receive a copy of this history within 60 days of my request and I understand that I may have to pay a reasonable charge of per page for any copies after the first requested in a 6 month period.
 - I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the Practice is not required to agree to the restrictions requested.
 - I understand that I may revoke this consent in writing, except to the extent that the Practice has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information.

Signature of Patient or Legal Representative

Date

Official use only

_____ Accepted

_____ Denied

Signature _____ Title _____ Date _____