NOTICE OF PRIVACY PRACTICES SUMMARY

Please read the following statements carefully. You may request to read our Notice of Privacy Practices in its entirety before you sign this summary of practices. Please keep page 1 for your records and sign page 2.

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Information regarding your health may be used and disclosed for the purpose of treatment, payment and other healthcare operations. Use and disclosure of your protected health information may be provided to a physician or other healthcare provider providing treatment to you. Your protected health information may be used and disclosed to obtain payment for services we provided to you. We may use and disclose your protected healthcare information in relations with our healthcare process. These processes include an assessment, improvement activities, reviewing the competence or qualifications of healthcare professionals, provider performances and evaluating practitioner, conducting training programs, accreditation, certification, licensing or credentialing activities.

At all times you have the right to review your protected health information with limited exceptions. At your request, we will provide your information in a format other than photocopies if we are able to do so. Your request to obtain access to your information must be in writing. We may need to charge you a reasonable cost-based fee for expenses including copies and staff time. If you request copies, we will charge you $0-$100 for each page and per hour for staff time to locate and copy your protected health information. Postage will be included if you wish to have your information mailed. If you request a format option which is different, we will charge a cost based fee for that format. You may choose to revoke your written permission at any time. The revocation must be in writing. If you revoke your written authorization, it will not affect any use or disclosure prior to the revocation.

Your rights include the choice to receive a review of every time we or our business associates disclosed your protected health information for reasons other than treatment, payment, healthcare information and certain other activities for the last six years but not before April 14, 2003. Additional reasonable cost based fees may be extended if your requests for such information are more than one time per year.

Your rights include the instruction to request how you are communicated to regarding your protected health information. Your request must be in writing and can spell out other ways or others locations regarding your protected health information communication. You must identify agreed upon explanations of payment arrangements under alternative communications.

You can initiate a written request to amend your protected health information. Included in the amendment must be an explanation of why your information should be amended. Certain conditions may exist where we may reject your request.

If you receive a notice electronically, you are entitled to receive the notice in writing as well.

CONSENT FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

This form authorizes the office of Dr. DiVito to use and disclose your protected health information (PHI) for the purposes of healthcare operations, treatment and payment activities.

Before signing, please read our Notice of Privacy Policies to gain a clear understanding of how we may use and disclose your PHI. For questions concerning our Notice of Privacy Policies contact our office.

Name: ________________________

Address: ______________________

City:___________________________ State: ___________ Zip: ___________

I have read your Notice of Privacy Policies and I consent to your use of my PHI for the purposes of healthcare operations, treatment and payment activities.

Signature:____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: ____

Relationship to Patient: ____

Acknowledgement of Receipt of Notice of Privacy Policies

This is to certify that I have received and read a copy of Dr. DiVito's Notice of Privacy Policies.

Signature:____

This information is intended as advisory in nature and should not be considered as legal advice nor is it a substitute for legal advice. This information does not constitute technical information system/security advice. It is designed to assist you in your own risk management activities. It is not intended to be exclusively relied upon or used as a substitute for your own loss-control program. Accuracy and completeness are not guaranteed.