Notice of Privacy Practices

This notice describes how the medical/protected health information about you may be used and disclosed and how you can get access to this information. Please read carefully.

Summary:

By law, we are required to provide you with our Notice of Privacy Practices. This Notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

This office uses and discloses your protected health care information for the following reasons:

1. To share with other treating health care providers regarding your health care
2. To submit to insurance companies to verify that treatment was rendered
3. To determine patient's health care benefits
4. To assist in overcoming a language barrier when caring for a patient
5. Releasing information required by State or Federal Health law
6. Emergency situations
7. Appointment reminders to household members or answering machines
8. Sign-in logs may be disclosed to verify office visits
9. Abuse, neglect or domestic violence

As a patient, you have the following rights:

1. The right to inspect and copy your information.
2. The right to request corrections to your information.
3. The right to request that your information be restricted.
4. The right to request confidential communications.
5. The right to report disclosures of your information.
6. The right to a paper copy of this Notice.

We want to assure you that your medical/protected health information is secure with us. This Notice contains information about how we will insure that your information remains private. If you have any questions regarding this Notice, you may contact Dr. Lundstrom (435) 649-4424.

Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that I have read a copy of this practice's **Notice of Privacy Practices.** I understand that if I have questions or complaints regarding my privacy rights that I may contact the person named above. I further understand that the practice will offer me updates to this **Notice** should it be amended, modified or changed in any way.

_____

Patient or Representative Name (**Please print**)

_____

Patient or Representative Signature Date

☐ Patient refused to sign ☐ Patient unable to sign because _____