NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

USES AND DISCLOSURES OF HEALTH INFORMATION

Treatment: We may use your health information for treatment or disclose it to a physician or other health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the Federal Privacy Rules for its payment activities.

Health Care Operations: We may use and disclose your health information for our health care operations. Health care operations include: quality assessment and improvement activities, reviewing competence of healthcare professionals, evaluation practitioner/provider relationships, conducting training programs, accreditation, certification, and credentialing or licensing activities. We may also disclose your information to another healthcare provider or organization that is subject to the Federal Privacy Rules and that has a relationship with you to support some of their health care operations.

On Your Authorization: You may give us written authorization to use your health care information or disclose it to anyone for any purpose. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

Family and Friends: We may disclose your health information to a family member, friend or other person to the extent necessary to help you with your health care or with payment for your health care. Before we disclose your health information, we will provide you with an opportunity to object to our use or disclosure. If you are not present or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We will also use our experience and professional judgment to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, or similar forms of health information.

Courtesy Calls & Appointment Reminders: We may use or disclose your health information to provide you with appointments reminders, courtesy calls, etc. via voicemail, email, postcards, and letters.

Public Benefit: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- As required by law
- For public health activities (disease/statistic & child abuse reporting, work-related illness or injury)
- To report abuse, neglect, or domestic violence
- In response to court and administrative orders and other lawful processes

YOUR RIGHTS - You Have The Right To:

- Request a copy of our Privacy Practices Notice at any time
- Look at and obtain a copy of your health information
- Deny courtesy calls, emails, or letters sent by our office
- Request a restriction on certain uses and disclosures of your health care information
- Receive confidential communications regarding your health information
- Revoke authorizations that you made previously in regards to your protected health information

OUR RESPONSIBILITIES - We Have The Right To:

- Maintain the privacy of your health information as required by federal and state law
- Provide you with a notice of our Duties and Privacy Practices
- Abide by the terms of this notice

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1705 South Pearl Street #4, Denver, CO 80210

Acknowledgment of Notice of Privacy Practices and Consent to Treat

With my consent, THE POINT may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to THE POINT's **Notice of Privacy Practices** for more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent.

With my consent, THE POINT may call my home or any other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, THE POINT may mail to my home or other designated location any items that assist the practice carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked as personal and confidential.

With my consent, THE POINT may email me appointment reminders and patient's statements. I have the right to request that THE POINT restrict how it uses or discloses my PHI to carry out TPO.

By signing this form, I am consenting to THE POINT's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, THE POINT may decline to provide treatment to me.

I, _____, hereby acknowledge that I read and reviewed a copy of THE POINT's Notice of Privacy Practices and fully understand this consent form. I am consenting to the use and/or disclosure of my health information to treat me and arrange for my medical care. I am consenting to be treated.

_____ _____

Signature of Patient or Parent/Legal Guardian *Date*

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