

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THE INFORMATION. PLEASE REVIEW CAREFULLY:

S.A.M.I. Myofascial Release is required by the Health Insurance Portability & Accountability Act of 1996 (HIPAA) to provide confidentiality for all health records and other individually identifiable health information in our possession. This Notice is to inform you of the uses and disclosures of confidential information that may be made by S.A.M.I. Myofascial Release, and of your individual rights and of S.A.M.I. Myofascial Release's legal duties with respect to confidential information.

Ways in which we may use and disclose your protected health information:

S.A.M.I. Myofascial Release may use and disclose at our discretion your medical records for each of the following purposes only: treatment, payment, and health care operations.

- **Treatment** means providing, coordinating or managing health care and related services.
- **Payment** means activities such as obtaining payment for the health care services we provide for you from your insurance or another third party payer.
- **Health care operations** include the business aspects of running a practice.

We will use and disclose your protected health information when required by federal, state or local law. Any other uses and disclosures will be made only with your written authorization. You will be provided with an authorization form upon request. A separate form will be needed for each request for release of information. The authorization for release of records is valid until it expires or is revoked. A written revocation of an authorization for release of records will be applied as of the date received by S.A.M.I. Myofascial Release. S.A.M.I. Myofascial Release and its staff will abide by such a written request, except to the extent that we have already taken actions relying on your authorization.

Please sign to indicate you understand my use of your information for treatment, payment, and health care operations as stated above.

Print_____

Sign_____

Date_____