# Notice of Privacy Practices

To our patients: This notice describes how health information about you (as a part of this practice) may be used and disclosed, and how you can get access to your health information. Please review this carefully. This is required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

**Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.**

**Use and disclosure of your health information in certain special circumstances**

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate officials.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official or correctional institution.
8. For Workers' Compensation or similar programs.

**Your rights regarding your health information**

1. Communications: You may request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than at work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by that agreement, except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to our office.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by our practice. To request an amendment, your request must be made in to our office.
5. Right to a copy of this notice. You are entitled to receive a copy of this notice. You may ask us to give you a copy of this notice at any time.
6. Right to file a complaint. If you believe that your privacy rights have been violated, you may file a complaint with our practice or the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our office. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact our office.

## Acknowledgement of Review of
## Notice of Privacy Practices

**I have reviewed this office's Notice of Privacy practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document again at any time.**

_____

Signature of Patient/Patient Representative | Printed Name of Patient/Patient Representative

_____

Date | Relationship (If Signed By Representative)

**If you have any questions or want to make a request pursuant to the rights described in our notice of privacy practices, please contact:**

Christie Garcia
Office Manager
2424 50th Street, Suite 100
Lubbock, TX 79412
Office: (806) 761-0722
Fax: (806) 797-1265