Digestive
MEDICINE ASSOCIATES, LLP

NOTICE OF PRIVACY PRACTICES SUMMARY

Effective April 1, 2003

You have our pledge and commitment to protect your medical information. We understand that medical information about you and your health is very personal. In fact, we are required by law to protect the privacy of your medical information and to provide you with a Notice of Privacy Practices, which describes:

How Medical Information about You May Be Used and Disclosed and How You can Access This Information.

We are required by law to have your written authorization before we use or disclose to others your medical information for purposes other than providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

We may be required or permitted by certain laws to use and disclose to other purposes without your authorization.

You also have important rights, which include:

- The Right to inspecting and copy of the Protected Health Information (PHI) we maintain about you
- The Right to request restrictions of your Protected Health Information (PHI)
- The Right to request to receive confidential communication s from us by alternative means or at an alternative location
- The Right to request an amendment of Protected Health Information (PHI)
- The Right to receive an accounting of certain disclosures we have made of your Protected Health Information (PHI)
- The Right to complain if you feel your rights have been violated

We have available a detailed Notice of Privacy Practices which fully explains Notice from time to time and a copy is available by calling our office. You have a right to receive a copy of our most current notice in effect if you have any questions, concerns or complaints about the Notice please contact our Privacy Officer at (305) 822-4107 or via fax at (305) 822-5086.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability Act of 1996 (HIPAA) that I have certain rights to privacy regarding my protected health information. I understand that the information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple health care for providers who may be involved in my treatment directly or indirectly
- Obtain payment from third party payers
- Conduct normal healthcare operation such as quality assessments and physical certification

I have received a summary of Digestive Medicine Associates Notice of Privacy Practices, but know that I can contact their Privacy Officer to obtain a detailed Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information.

I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions but if you do agree that you are bound to abide by such restrictions.

Patient Name: _____ Patient Signature: _____ Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of Notice of Privacy Practices but was unable to do so and documented below:

Date: _____ Initials: _____ Reason: _____