

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

<p><u>Your Rights</u></p> <p>You have the right to:</p> <ul style="list-style-type: none"> •Get a copy of your paper or electronic medical record •Correct your paper or electronic medical record •Request confidential communication •Ask us to limit the information we share •Get a list of those with whom we've shared your information •Get a copy of this privacy notice •Choose someone to act for you •File a complaint if you believe your privacy rights have been violated 	<p><u>Your Choices</u></p> <p>You have some choices in the way that we use and share information as we:</p> <ul style="list-style-type: none"> •Tell family and friends about your condition •Provide disaster relief •Include you in a hospital directory •Provide mental health care •Market our services and sell your information •Raise funds
<p><u>Our Uses and Disclosures</u></p> <p>We may use and share your information as we:</p> <ul style="list-style-type: none"> •Treat you •Run our organization •Bill for your services •Help with public health and safety issues •Do research •Comply with the law •Respond to organ and tissue donation requests •Work with a medical examiner or funeral director •Address workers' compensation, law enforcement, and other government requests •Respond to lawsuits and legal actions 	<p><u>Our Responsibilities</u></p> <ul style="list-style-type: none"> •We are required by law to maintain the privacy and security of your protected health information. •We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. •We must follow the duties and privacy practices described in this notice and give you a copy of it. •We will not use or share your information other than as described here unless you tell us we can in writing. <p>If you tell us we can, you may change your mind at any time.</p> <p>Let us know in writing if you change your mind.</p> <p>For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.</p>

We will provide you a further explanation of the items on this disclosure if you request. Please sign that you have read and understand your patient rights.

Signature _____

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