DYNAMIC ARTHRITIS CARE CLINIC, PLLC
CARLOS E. RAMIREZ, M.D.
BOARD CERTIFIED INTERNAL MEDICINE & RHEUMATOLOGY

HIPAA PRIVACY PRACTICES
As required by the Health Insurance Portability and Accountability Act of 1996
Consent to Use and Disclose Protected Health Information

Use and Disclosure of Your Protected Health Information

Your protected health information will be used by the office of Dynamic Arthritis Care Clinic or disclosed to others for the purpose of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices

The office of Dynamic Arthritis Care Clinic is required to provide at your request a notice that describes how information about you may be used and disclosed. Additionally, we must provide you information on how you may get access to this information. The policies and practices are defined in the "Notice of Privacy Policies and Practices" brochure provided to you at your request.

Requesting a Restriction on the Use of Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information. The office of Dynamic Arthritis Care Clinic may or may not agree to restrict the use or disclosure of your protected health information.

If the office of Dynamic Arthritis Care Clinic agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices

The office of Dynamic Arthritis Care Clinic reserves the right to modify the privacy practices outline in the notice. I understand that the office of Dynamic Arthritis Care Clinic will notify me of these changes via the method I have authorized or upon my next appointment.

Signature

I have given my permission to the office of Dynamic Arthritis Care Clinic to use and disclose my health information in accordance with this consent and the notice provided.

_____
Name of Patient (Please Print)

_____ _____
Signature/ Responsible Party Date