LAGUNA BEACH OBSTETRICS & GYNECOLOGY

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TO OUR PATIENTS:

The privacy of your health information is very important to us. We want you to understand how we use and disclose your information and your rights to this information. We ask you to please review our Notice of Privacy Practice that describes our legal duties with respect to your health care and information.

HOW WE USE HEALTH CARE INFORMATION:

We use information about you to:

- ✓ Provide optimal treatment for you
- ✓ Insure appropriate payment for the treatment we provide
- ✓ Monitor the quality of our operation

WHEN WE MAY DISCLOSE INFORMATION:

In certain limited cases we are permitted to disclose health care information about you, for example, when there is a serious threat to your health and safety, for workers compensation, to reduce public health risks, or when concerned with law enforcement. In addition, we may disclose information to tell you about related services and alternate treatments, and to discuss health-related research with your permission.

YOUR INFORMATION RIGHTS:

You will have the right to know how we use your health information, who we can give it to, and your rights to this information. (Please see our Notice of Privacy Practices).

You have the right to ask us to restrict our uses and disclosures where we believe such restrictions will not harm you and where it is possible for us to do so.

You have the right to confidential communication of your heath care information. For example, you may ask for a conversation to be held in private or for your billing to go to another address.

You have the right to review or copy any information in your chart unless the doctor feels this would be harmful to you or someone else.

You have the right to request that we amend your records if we agree it is inaccurate or incomplete.

You have the right to ask us for information regarding the disclosure of your health information to someone other than the individuals involved directly with your health care or when you have authorized the release of information.

Please sign below to indicate that you have received our Notice of Privacy Practices. If you have any questions, please speak to your physician or the office manager.

Signature:_______________________________________ **Date:**__________________

Print Name:_____________________________________