Revised 10/24/2011

Central California Neurology Medical Corporation
Summary of Notice of Privacy Practice

The Health Insurance Portability and Accountability act of 1996 ("HIPAA") requires that, effective April 14, 2003, we provide you a printed copy of Notice of Privacy Practices. For your convenience, we are providing this brief summary. A copy of our full Notice is available, which we encourage you to read in its entirety. We are required to ask you to sign a one-time acknowledgment that you have received this summary. A copy of the full Notice is available upon request.

Your Rights As A Patient
You have rights with respect to your protected health information. These are summarized below and described in detail in our full Notice of Privacy Practices.

Use of Protected Health Information
We are permitted to use your protected health information for treatment purposes, payment and to conduct our business and evaluate the quality and efficiency of our processes. Also, we are permitted to disclose protected health information under specific circumstances to other entities. We have put into place safeguards to protect the privacy of your health information. However, there may be incidental disclosures of limited information, such as overhearing a conversation, that occur in the course of authorized communications, routine treatment, payment, or the operations of our practice. HIPAA recognizes that such disclosures may be extremely difficult to avoid entirely, and considers them permissible.

Disclosures Of Protected Health Information Requiring Your Authorization
For disclosures that are not related to treatment, payment or operations, we will obtain your specific written consent, except as described below.

Disclosures Of Protected Health Information Not Requiring Your Authorization
We are not required by state and federal law to make disclosures of certain protected health information without obtaining your authorization. Examples include mandated reporting of conditions affecting public health, subpoenas, and other legal requests.

Restrictions To Use And Disclosure
You may request restrictions to the use or disclosure of your protected health information, but we are not required by HIPAA to agree to such requests. However, if we do agree, only the minimum amount of such information will be used to accomplish the intended goal.

Access To Protected Health Information
You may request access to or a copy of your medical records in writing. If we deny the request, we will tell you why. You may appeal this decision, which, under specified circumstances, will be reviewed by a third party not involved in the denial.

Amendments To Medical Records
You may request in writing that corrections be made to your medical records. We will either accept the amendments, and notify appropriate parties, or deny your request with an explanation. You have rights to dispute such denials and have your objections noted in your medical records.

Accounting Of Disclosures Of Protected Health Information
You may request in writing an accounting of disclosures of your protected health information. This accounting excludes disclosures made in the course of treatment, payment, or operations.

Complains Related To Perceived Violations Of Your Privacy Rights
You may register a complaint about any of our privacy practices with our Privacy Officer or with the Secretary of Health and Human Services.

Use and disclosure of protected health information is required by federal law known as The Health and Insurance Portability and Accountability Act of 1996 (HIPAA).

Under HIPAA, providers of healthcare are required to give patients their Notice of Privacy Practices for Protected Health Information and make a good faith effort to obtain a written acknowledgment that this notice was received.

Therefore, I_____, acknowledge that
(printed name of patient or personal representative)

Central California Neurology Medical Corporation, has provided a written copy of their summary Notice of Privacy Practices to (check one) _____myself _____or other, specify_____.

X_____ _____
Signature of Patient or Personal Representative Date

I give the office consent to download my prescription medication history for electronic prescribing.

X_____ _____
Signature of Patient or Personal Representative Date