Notice of Privacy Practices

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.

Understanding Your Health Record/Information
This notice describes the practices of (FACE OF THE VALLEY AESTHETICS, LLC) and its staff (collectively, "**Practice**"), and that of any physician or provider with staff privileges with respect to your protected health information created while you are a patient at Practice. Practice, physicians with staff privileges and personnel authorized to have access to your medical chart are subject to this notice. In addition, Practice and physicians with staff privileges may share medical information with each other for treatment, payment or health care operations described in this notice.

We create a record of the care and services you receive at Practice. We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. This notice applies to all the records of your care at Practice.

This notice will tell you about the ways in which we may use and disclose medical information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of medical information.

Your Health Information Rights
Although your health record is the physical property of Practice, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information for treatment, payment and health care operations, and as to disclosures permitted to persons, including family members involved with your care and as provided by law. However, we are not required by law to agree to a requested restriction, unless the request relates to a restriction on disclosures to your health insurer regarding health care items or services for which you have paid out of pocket and in full;
- Obtain a paper copy of this notice of information practices;
- Inspect and request a copy of your health record as provided by law;
- Request that we amend your health record as provided by law. We will notify you if we are unable to grant your request to amend your health record;
- Obtain an accounting of disclosures of your health information as provided by law; and
- Request communication of your health information by alternative means or at alternative locations. We will accommodate reasonable requests.

You may exercise your rights set forth in this notice by providing a written request to (FACE OF THE VALLEY AESTHETICS, LLC): (COMPANY ADDRESS).

Notice of Privacy Practices Acknowledgement

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

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly;
- Obtain payment from third-party payers; and
- Conduct normal health care operations, such as quality assessments and physician certifications.

I acknowledge that I have been provided the *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 at the address above 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, then you are bound to abide by such restrictions.

_____ *(initials)* I acknowledge that my medical information/records will be released to Practice. I further acknowledge that my medical information/records will be released from Practice to my primary care provider, referring/consulting providers and my insurance company to process insurance claims.

I also allow release of my medical information to the following individuals (i.e. family, caregivers, etc.):

Name:	**Relationship:**
_____	_____
_____	_____
_____	_____

_____		_____
Printed Patient Name	**Date**	**Signature of Patient**

Giacinta Roupas, CRNA, Owner	*Giacinta Roupas, CRNA*
Practice Representative Name	**Signature of Practice Representative**