

SUMMARY OF NOTICE OF PRIVACY PRACTICES

A detailed Notice of our office Privacy Practices is available upon request.

The following summary outlines how our office will protect your health information, your rights as a patient and our common practices in dealing with your health information.

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization.

In the following circumstances, we may disclose your health information **without** your written authorization.

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations and other oversight activities;
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and as otherwise required by the law.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please submit your concerns in writing to:

Dr. Christopher P. Segler
236 West Portal Ave, #332
San Francisco, CA 94127

236 WEST PORTAL AVENUE, SUITE #332, SAN FRANCISCO, CA 94127-1423
PH: (415) 308-0833 Fx: (650) 993-8574

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Cell phones, email and Skype all have inherent insecurities. Please initial each section if you wish to use these and accept the security risks inherent in these technologies.

Please **initial** if you would like to communicate via **email, text messages** or **voicemail**:

_____ I authorize Dr. Segler to provide my Health Information as a **voicemail** at the following telephone number _____
(enter your preferred telephone number here)

_____ I authorize Dr. Segler to provide my Health Information via **email**.
I understand and accept the inherent limitation in security associated with email accounts.
I authorize receipts and health information to the following email address(es):

(enter your preferred email address here)

_____ I authorize Dr. Segler to provide my Health Information via **Skype**.
I understand and accept the inherent limitation in security associated with web programs accounts. I authorize health information to the provided at the following Skype address:

(enter your preferred email address here)

_____ I authorize Dr. Segler to provide my Health Information as **text messages** at the following cell phone number _____
(enter your preferred telephone number here)

Patient Name (please print)

Date

Patient Signature

Parent or Authorized Representative (applicable if patient is a minor)