

GARY KNIGHTON, D.O.

2152 S. Vineyard Dr., Suite 135

Mesa, AZ 85210

(480) 539-1855

(480) 539-1859 - Fax

NOTICE OF PRIVACY FOR: Patient's Protected Health Information

This notice describes how health care information about you may be used and disclosed as well as how you can get access to this information. Please review it carefully and return to our office.

This office abides by the terms described in this policy. This office uses and discloses your protected health care information for the following reasons:

- 1) To share with other treating health care providers regarding your health care.
- 2) To submit to insurance companies or Workers Compensation Claims to verify that treatment has been rendered.
- 3) To determine patient's benefits in a health care plan.
- 4) Releasing information required by State or Federal Public Health law.
- 5) To assist in overcoming a language barrier when caring for a patient.
- 6) Business associates/staff providing written assurances for your privacy have been attained.
- 7) Emergency situations.
- 8) Abuse, neglect or domestic violence.
- 9) Appointment reminders to household members or answering machines.
- 10) Sign-In logs may be disclosed to verify office visits.

Any other uses or disclosures will only be made after your specific written authorization.

You have the right to:

- 1) Revoke authorization, in writing, at any time by specifying what you want revoked, restricted and to whom.
- 2) Speak to our privacy officer who is Amy Schad, and she can be reached at 480-539-1855 regarding privacy issues.
- 3) Inspect, copy and amend your protected health information and amend it as allowed by law.
- 4) Obtain an accounting of disclosures of your protected health information.
- 5) To render a complaint to our privacy officer or the Secretary of Health and Human Services.

This office reserves the right to change the terms of this notice and to make new notice provisions for all protected health information that it maintains. Patients may also get an updated copy upon request at any time by asking the staff of this office.

I acknowledge that I have received and reviewed this notice with full understanding.

Name of Patient (Print)

Signature of Patient/Legal Representative

Date