David K. Padgett, D.O.

Physical Medicine and Rehabilitation
Osteopathic Manipulative Medicine
Electrodiagnostic, Sports & Pain Medicine

Notice of Privacy Practices

All information that is obtained from you by this office is protected and kept confidential. Every reasonable measure to prevent unauthorized disclosure of your protected health information is practiced.

Uses and Disclosures

- Your protected health information is accessed and used for healthcare related purposes only.
- Your protected health information is never sold, rented, transferred, exchanged, and/or used for non-healthcare related purposes including marketing activities without your written authorization.
- Your protected health information is disclosed to third-party entities without your written authorization for the purpose of treatment, to obtain payment for treatment, and for healthcare operations.

Certain Circumstances

Your protected health information can be disclosed without your written authorization in certain limited circumstances,

- Medical emergencies
- IN situation required by law
- Individuals involved in your care
- When requested by public health agency
- When requested by a law enforcement agency

For any purpose other than treatment, obtaining payment, healthcare operations, or certain circumstances, we will ask for your written authorization before using or disclosing your protected health information. If you choose to sign an authorization to disclose protected health information, you can revoke that authorization in writing at any time.

Patient Rights

- You have the right to request in writing to inspect and/or receive a copy of your health information.*
- You have the right to request an alternate means of location to receive communications regarding your health information.*
- You have the right to request in writing to amend, correct, or delete any recorded health information with in our possession.*
- You have the right to request in writing to restrict some of the uses and disclosures of your health information.*
- You have the right to request in writing an accounting of certain disclosures of your health information that were made by this office.*

* Conditions and limitation may apply; obtain additional information from front desk.

Changes To This Notice: *We reserve the right to change privacy practices an the condition s of the notice at any time and without prior notice. In the event of changes, and update notice will be posted and a copy will be sent to you.*

4125 Blackhawk Plaza Circle, Suite 100, Danville, CA 94506

Office: (925) 314-9222 **FAX: (925) 314- 9822**

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Consent to the Use and Disclosure of Health Information

Name________________________________DOB_______________SS#_________________

In understand that as part of my healthcare, Dr. Padgett originates and maintains health records describing my health history, examination and test results, diagnoses, treatment, and any plans for future care of treatment.

I understand that The Notice of Privacy Practices information serves as:

- A basis for planning my care and treatment.
- A means of communication amongst the many healthcare or professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

☐ I request the following restrictions to the use or disclosure of my health information:

Medical information can be discussed with:
☐ Patient Only
☐ Family member or friend___________________
☐ Physician
☐ Other____________________________________

Detailed messages regarding test results can be left on my answering machine/voicemail:
☐ Yes ☐ No ☐ Phone #________________

☐ Other Restrictions____

I acknowledge that I have been provided an opportunity to review the Notice of Privacy Practices for Dr. Padgett.

______________________________________ ____________
Signature of Patient or Legal Representative Date

Form: HIPAA Patient Disclosure as of 4/7/14

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