

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES.

1844 San Miguel Drive Suite 316
Walnut Creek, CA 94596
925-938-5252

“We respect your right to privacy and understand that your medical information is personal to you. Your personal health information is confidential and this notice is intended **in summary** to help you understand how our practice uses and discloses your personal health information and what right you have with respect to your medical information.”

How We May Use and Disclose Your Information:

Medical Treatment:

- We may need to share information relating to your medical care, records, treatment with other physicians, nurses, health care professionals and the Neurological Research Institute of the East Bay.

Payment:

- We may need to disclose personal health information about you with your health plan and/or referring physician in order to obtain prior authorization for treatment, or to determine whether payment for the treatment is covered by your plan or to facilitate payment of a referring physician.

Healthcare Operations:

- We may use and disclose your personal health information to business associates who need to provide a service for our medical practice; examples are our transcriptionist and medical biller.

Appointment Reminders:

- Our practice may use and disclose medical information about you to provide you with reminders that you have an upcoming appointment. If you have any special requests about these reminders, please notify us.

Please select all that apply. Sign and date below.

PROTECTED HEALTH INFORMATION

Laboratory, x-ray or scan results, medical records, medications, billing matters and/or any correspondence pertaining to Protected Health Information

I hereby authorize Michael Stein, MD or staff to leave messages at the following:

- DO NOT LEAVE A MESSAGE OTHER THAN TO RETURN THE CALL
- YES NO-Answering machine or voice mail.
- YES NO-Home phone _____ YES NO-Work phone _____
- YES NO-Cell phone _____ YES NO-Other phone _____
- YES NO-Please mail results or correspondence to: _____

If you would like your Protected Health Information disclosed to other family members or friends, please indicate their name and relationship. Only the names listed will be given information.

Name Relationship Address or phone

Name Relationship Address or phone

I hereby acknowledge that I have read this Notice of Privacy Practices. I further acknowledge that the entire Notice of Privacy Practices is in the waiting room for review, and you will be offered a **complete** copy of the Privacy Practices upon request.

Signed: _____ Date: _____

Print Name: _____