SUZANNE M. DUPÉE MD
A PROFESSIONAL MEDICAL CORPORATION

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

TO OUR PATIENTS,

The privacy of your health care information is extremely important to us. We want you to understand how we use and disclose your information and your rights to this information. We ask you to review our Notice of Privacy Practices that describes our legal duties with respect to your health care information.

HOW WE USE HEALTH CARE INFORMATION

In summary, we use information to:

- Provide treatment to you
- Ensure appropriate payment for the treatment we provide
- Monitor the quality of our operations

WHEN WE MAY DISCLOSE INFORMATION

Under certain limited cases, we are permitted to disclose health care information about you. Examples include: a serious threat to health or safety, for worker's compensation, to reduce public health risks, for health oversight and in certain cases for law enforcement. In addition, we may disclose information to tell you about health-related services and alternative treatments, and to conduct health-related research with your permission.

YOUR INFORMATION RIGHTS

We create a record of the care we give you. You have the following rights to this information:

- You have the right to know how we use your health information, who we can give it to and your rights to this information. (Please see our Notice of Privacy Practices).
- You have the right to ask us to restrict uses and disclosures where we believe such restriction will not harm you and where it is possible for us to do so.
- You have the right to confidential communication of your health information. For example, you can ask for a conversation to be held in private or for us to send a copy of your bill to a different address.
- You have the right to look at and get a copy of information in our records unless your doctor has indicated that this would be harmful to you or someone else.
- You have the right to request that our records be amended if we agree it is inaccurate or incomplete.
- You have a right to ask us for a list of any of the following: when we have disclosed your health information to someone other than those treating you, handling your bills, for our internal operations or when you have authorized release of information.

PLEASE SIGN BELOW THAT YOU HAVE RECEIVED OUR NOTICE OF PRIVACY PRACTICES. IF YOU HAVE ANY QUESTIONS, PLEASE SPEAK TO YOUR PHYSICIAN.

SIGNATURE:_____**DATE:**_____

PRINT NAME:_____**SS#:**_____

IN ACCORDANCE WITH LEGAL REQUIREMENTS, YOUR PERSONAL HEALTH INFORMATION MAY BE RETAINED FOR SIX YEARS AFTER THE CLOSE OF TREATMENT