Summary Of Notice Of Privacy Practices

Cura Centers

65 Albany Turnpike, PO Box 466, Canton, CT 06019
Rachel Devlin, Privacy Officer
(860) 693-6226

The following is a brief summary of your rights and our responsibilities as detailed in the attached Notice of Privacy Practices (the "Notice"). This Summary is for your convenience and is not a substitute for reading the entire Notice and does not modify the terms of the Notice.

1. **Uses and Disclosures of Your Health Information.** We may use the information we develop and collect for treatment by our practice or disclose the information to others to whom we refer you for treatment, for payment for these services and for certain health care "operations" such as improving the competence and quality of our staff and business planning and management. We may disclose your information to our business associates such as medical transcriptionists, billing services and others who assist in the operations of our practice. We may call you to remind you of appointments and may leave a message on your answering machine if you have one. We may also disclose information to your family about your location, general condition or death. If you are available and able, we will ask your consent first. We may also use your information to recommend products or services related to your care but will not use or disclose your medical information for marketing purposes without your written authorization. Your medical information may be disclosed without your authorization as required by law, for public health purposes, healthcare oversight, including audits and investigations, judicial and administrative proceedings, subject to the limits imposed by state and federal law, and certain other purposes.

2. **Other Uses and Disclosures**. Except as described in the Notice, we will not use or disclose your medical information without your written authorization. You can revoke an authorization at any time, except to the extent that we have already taken action in reliance on the authorization.

3. **Your Health Information Rights**. You have a number of rights under state and/or federal law which are subject to the terms and conditions specified in the Notice:
    a) You may request restrictions on certain uses and disclosures of your information
    b) You may request that you receive your information from us in a certain way
    c) You may inspect and copy your medical records
    d) You may request an amendment to any record you believe is inaccurate
    e) You may request an accounting of disclosures made of your records

4. **Changes to the Notice**. We reserve the right to change the Notice. If we do so, we will post it in our office, and provide a copy upon request.

5. Complaints. You may file a complaint to our Privacy Official whose name is above or with the federal government as detailed in the Notice. You will not be penalized for filing any complaint.

Canton Physical Therapy
HIPAA CONTACT INFORMATION

May we leave a message regarding your appointment and/or medical information?
(please circle YES or NO. If left blank it is assumed a YES)

Home Phone (including automated appointment reminders):_____ YES NO

Work Phone: (including automated appointment reminders):_____ YES NO

Cell Phone: (including automated appointment reminders):_____ YES NO

Cell Phone - Text: (including automated text appointment reminders):_____ YES NO

Send via Mail: YES NO

Send via Email (including office updates): _____ YES NO

With Another Person: YES NO

Please list person(s) authorized to discuss medical information with:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Acknowledgement of Receipt of Notice of Privacy Practices

Rachel Devlin, Privacy Officer (860)-693-6226

Name of Patient: _____

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

Signed: _____ Date: _____

Print Name: _____

If not signed by the patient, please indicate your relationship to the patient: _____

***For Office Use Only*:**

Signed form received by: _____

Acknowledgment refused:

Efforts to obtain:_____

Reasons for refusal:_____