Robert S. Howe, M.D., F.A.C.O.G. • Lisa Howard, M.D. • Sonia L. Krotkov, PA-C
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Summary Notice of Privacy Practices

Our practice is dedicated to maintaining your privacy. In providing care to you, we create records regarding you and our treatment and services. We are required by Federal Privacy Regulations, which were created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to show that we maintain the confidentiality of your health information.

HIPAA gives force to law to several important concepts, which we have always followed. We have never disclosed patient information to any person or party without the patient's request and permission. We have always made charts available to patients: after all, the chart is ours, but it is about you. Thus, HIPAA does not change the care you will receive, nor our respect for your privacy. Our practice complies with HIPAA's regulations; you can ask to see a more detailed Privacy Policy in our office.

Our practice will use or disclose your personal information only as necessary to provide quality patient care and in our normal business operations. We will disclose your personal health information, with your consent, to other physicians with whom we may work in caring for you. We will use or disclose your personal information in order to bill and collect payment for the services you receive from us. Our practice will also use or disclose your personal information to contact you and remind you of your appointments.

In order to use or disclose your personal health information for these purposes, we are legally obliged to obtain a signed consent. It is important that you know that you have the right to request a restriction of the use or disclosure of your information to only certain individuals or certain locations. The office can provide you with an authorization form for these restrictions.

CONSENT FOR USE OF PERSONAL HEALTH INFORMATION

I hereby authorize Dr. Robert Howe's Practice to use and/or disclose my personal health information in accordance with their privacy policies to carry out my treatment, payment and health care operations.

I understand that Dr. Robert Howe's Practice has prepared a more detailed Privacy Policy and that I have the right to review that policy at any time during normal office hours.

I have the right to request restrictions on how my personal health information if used and/or disclosed and may authorize those changes at any time.

____ ____________________
Signature of patient or patient's representative Date

____ ____________________
Printed name of patient or patient's representative Relationship to patient

Rev 2/12