PORTSMOUTH
1 Cate Street | Portsmouth, NH 03801
P: 603-431-0277 | **F:** 603-422-8849

DOVER
60 Pointe Place, Suite 1 | Dover, NH 03820
P: 603-740-1300 | **F:** 603-740-0060

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. ***Please review this notice carefully!*** We are required by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices to your protected health information.

Disclosure of Your Health Care Information: We may use and release your medical information (clinical and billing) for any of the following below:

Treatment: We may disclose your health care information to other health care professionals such as your referring doctor, primary care physician, physician's assistants, nurses or other supporting staff, other providers and staff within our practice for the purpose of treatment, payment or health care operations.

Payment: We may disclose your health information to your insurance provider for the purpose of payment or health care operations. Workers' Compensation: We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies: We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care, about your medical condition or in the event of an emergency or of your death.

Public Health and Safety: As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting infection or disease exposure. It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

Marketing: We may contact you for marketing purposes, such as testimonials for brochures or our website.

Appointment Reminders: As a courtesy to our patients we may place a call to your home a day or more, prior to a scheduled appointment to remind you of your appointment time. If you are not home, we will leave a message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment as well as a request to call our office if you have any questions or need to cancel or reschedule your appointment. We may also call your home if you are late to your scheduled appointment to verify that you are on your way, the same guidelines would be used as above for this call.

Change of Ownership: In the event that this practice is sold or merged with another organization, your health information/record will become the property of the new owner.
We may also disclose and release your medical information for the following: Judicial and Administrative Proceedings, Law Enforcement, Organ Donation, Research, Deceased Persons-we may disclose your health information to coroners or medical examiners, Specialized Government Agencies.

Your Health Information Rights: Although your health record is the physical property of the healthcare provider, you have the right to:

Request Amendments: You have the right to request this practice amend your protected health information if you feel the information is incorrect or incomplete. You have the right to request an amendment for as long as the information is kept by or for the provider. We are not required to agree to amend your protected health information and may deny your request. If this occurs, you will be notified of the reason in writing.

An Accounting of Disclosures: You have the right to request an accounting of your protected health information made by this practice. Please be advised, this practice is not required to agree to the restriction that you request.

Request Restrictions: You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, this practice is not required to agree to the restriction that you request.

Request Confidential Communications: You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication such as mail, fax, phone, or delivery, upon your request. We reserve the right to contact you by other means and at other locations if you fail to respond to communications from us.

Complaints: Complaints about your privacy right's, or how this practice has handled your health information should be directed to our Privacy Officer.

(OVER)

Changes to this Notice of Privacy Practices: This practice reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, this practice is required by law to comply with this notice. This practice is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice, or if you want more information about your privacy rights, please contact our Privacy Officer or the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing.

Privacy Officer: David Burchuk, PT, ATC (603) 431-0277.

By way of my signature, I acknowledge receipt of this notice and provide this practice with my authorization and consent to use and disclose my protected health care information for the purpose of treatment, payment and health care operations as described in the Privacy Notice. I acknowledge that I have read this notice and understand the information that has been provided to me.

______________________________ ____________________

Print Patients Name Date

______________________________ ____________________

Patient’s Signature Guardian’s Signature if under age 18