NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THE INFORMATION. PLEASE REVIEW CAREFULLY:

I am required by the Health Insurance Portability & Accountability Act of 1996 (HIPAA) to provide confidentiality for all medical/mental health records and other individually identifiable health information in my possession. This Notice is to inform you of the uses and disclosures of confidential information that may be made by BIS Community Clinic, LLC, and of your individual rights and BIS Community Clinic, LLC's legal duties with respect to confidential information.

Ways in which BIS Community Clinic may use and disclose your protected Health information: We may use and disclose your medical records for each of the following purposes only: treatment, payment and health care operations.

- **Treatment** means providing, coordinating or managing health care and related services.
- **Payment** means activities such as obtaining payment for the health care services I provide for you from your insurance or another third party payer.
- **Health care operations** include the business aspects of running a practice.

We may contact you to provide appointment reminders or other services that may be of interest to you. I will disclose your protected health information to any person you identify that is involved in payment for your care.

Any other uses and disclosures will be made only with your written authorization. You will be provided with an authorization form upon request. A separate form will be needed for each request for release of information. The authorization for release of records is valid until it expires or is revoked. You may revoke authorization in writing a I am required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

By signing this authorization I also grant BIS Community Clinic medical assignment of benefits, as well as authorization to electronically obtain insurance benefits and electronic medication history.

Please sign to indicate you understand my operation use of your information for treatment, payment and health care operations as stated above.

[{[Signature]}] [{[DateSigned]}]