

## 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 READ IT CAREFULLY.

TRE Medical, Ltd. Is committed to keeping your verbal communication and clinical records strictly confidential except to use or disclose health information to carry out treatment, obtain payment, and for health care operations. In addition authorization of the following can be released per HIPAA regulations:

- 1) Release (when required) of: Diagnosis, Evaluation and/or treatment for alcohol and/or drug abuse; Records of HTLV-III OR HIV testing (AIDS test) result, diagnosis and/or treatment; Psychiatric, psychological records or evaluation and/or treatment for mental, physical and/or emotional illness including narrative summary, tests, social work assessment, medication, psychiatric examination, progress notes, consultations, treatment plans, and/or evaluation.
- 2) My medical condition and information may be discussed with the following persons:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

- |  |     |    |
|--|-----|----|
| 3) Leave a message on my cell phone?                                 | YES | NO |
| 4) Leave a message on my home phone voice mail or answering machine? | YES | NO |
| 5) Leave a message with the person who answers my home phone?        | YES | NO |
| 6) Contact me at work and tell them who is calling if asked?         | YES | NO |
| 7) Leave a message on my work phone voice mail or answering machine? | YES | NO |
| 8) Contact me through email?   | YES | NO |

For billing purposes and appointment conformation only.

\_\_\_\_\_  
Signature of Patient (or patient's representative)

\_\_\_\_\_  
Date  
This authorization expires 3 years from execution

\_\_\_\_\_  
Printed Name of Patient (or Patient's representative)

\_\_\_\_\_  
Relationship to Patient