

Alta California Medical Group Notice of Privacy Practices, Short Form
The Privacy Officer is our Office Manager

This notice describes how your health information may be used and disclosed and how you can access this information. It is important that you understand this information.

At Alta California Medical Group, we have always kept your health information secure and confidential. A new law now requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

- The law permits us to use or disclose your health information to those involved in your treatment. For example, a provider in this office may arrange for a review of your file by a specialist provider whom we may involve in your care.
- We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.
- We may use or disclose your health information with our normal healthcare operations. For example, one of our staff will enter your information into our computer.
- We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.
- We may use your information to contact you. For example, we may send newsletters or other information to you. We may also want to call and remind you about your appointment. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.
- In an emergency, we may disclose your health information to a family member or another person responsible for your care.
- We may release some or all of your health information when required by law.
- If this practice is sold, your information will become the property of the new owner.
- Except as described above, this practice will not use or disclose your health information without your prior written authorization.
- You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.
- You have the right to know of any uses or disclosure we make with your health information beyond the above normal uses.
- As we need to contact you from time to time, we will use whatever address or telephone number you prefer.
- You have the right to transfer copies of your health information to another practice. We will mail your files to that office upon receipt of a signed release form and the associated fee.
- You have a right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies. You will also be charged a fee to review your records.
- You have the right to request an amendment of your health information. Give us your request to make changes in writing. These changes are done in the form of a written statement of 250 words or less. We will not change the medical record itself but will include your written statement in the chart. If the provider agrees with your written statement he/she may update the medical record along with keeping your written statement in your file.
- You have a right to receive a copy of this notice and the longer version of this notice. If we change any of the details of this notice, we will notify you of the changes in writing. You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer, which is our Office Manager at 805 578-9616. This notice goes into effect on April 14, 2003.

ACKNOWLEDGEMENT: I have received a copy of the Alta California Medical Group Notice of Privacy Practices.

DATE: _____ SIGNED: _____

PRINT NAME: _____

If signing as a parent or guardian, please note the name of the patient: _____