The following categories describe different ways that we use and disclose your PHI. We have provided you with examples in certain categories; however, not every use or disclosure in a category will be listed.

For Treatment – To healthcare personnel at **Carmichael's** or any independent and third party entities who are involved in taking care of you.

For Payment – To bill you, your insurance company or a third party or in connection with various payment-related functions.

For Healthcare Operations – To review our treatment and services and to evaluate the performance of our staff in caring for you, or to disclose information to nurses, doctors, technicians, nursing staff and other personnel for review and learning purposes.

The following categories describe different ways that we are permitted to use or disclose your PHI:

For Appointment Reminders and Follow-up Calls – To leave a message with an answering service or on your answering machine or other similar voicemail or recording device.

To Communicate with Individuals Involved in Your Care or Payment for Your Care – To disclose, to a family member, other relative, close personal friend or any other person you identify, PHI directly relevant to that person's involvement in your care or payment related to your care.

For Research – To facilitate or to be used regarding medical research purposes, under certain circumstances.

As Required By Law – To comply with the provisions of federal, state or local law.

To Avert a Serious Threat to Health or Safety – To assist with or to help prevent threat to your or another person's health and safety.

Organ and Tissue Donation – To assist organizations that handle organ procurement or organ, eye or tissue transplantation.

Military and Veterans – To comply with requirements of military command authorities, if you are a member.

Workers' Compensation – To comply with requests from workers' compensation or similar programs.

Public Health Risks – To facilitate public health activities.

must submit a request in writing to our Compliance Officer (contact information is presented at the conclusion of this Notice). Your request must specify the time period. The time period may not be longer than six (6) years and may not include dates before April 14, 2003.

Right to Request Communications of PHI by Alternative Means or at Alternative Locations – To request communications of PHI by alternative means or at alternative locations. For instance, you may request that we contact you at a different residence or post office box. To request confidential communication of your PHI, you must submit a written request to our Compliance Officer (contact information is presented at the conclusion of this Notice). Your request must specify how or where you would like to be contacted. We will accommodate all reasonable requests.

OTHER

Authorization Rule

We will not use or disclose your PHI for any purpose or to any person other than as stated in the foregoing rules without your signature on our specifically worded, written authorization form, the "Medical Information Release Form," which form is presented at the conclusion of this Notice or is available to you from any of the facility locations of **Carmichael's** or from our Compliance Officer (contact information is presented at the conclusion of this Notice). If we require your authorization, we must obtain it through the use of this Medical Information Release Form, which may be separate from any authorization or acknowledgement we may have obtained from you otherwise. We will not condition your treatment upon whether or not you sign any authorization or acknowledgement form.

Incidental Disclosures

Carmichael's will make reasonable efforts to avoid incidental disclosures of PHI. An example of an incidental disclosure is a

FOR MORE INFORMATION, YOU MAY CONTACT EITHER:

Diane Hritz

Medical Information Release Form

(HIPAA Release Form)

Name_____ **DOB**_____

( ) I, the Undersigned, hereby do authorize the release of my medical information, including documentation regarding prescription, description of treatment rendered, claim and any other relevant medical record or information, to the following individual(s) or entity(ies):

( ) Spouse _____

( ) Child(ren) _____

( ) Other _____

( ) I, the Undersigned, hereby do prohibit the release of my medical information to anyone.