Summary 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 IT CAREFULLY-IT IS FOR YOUR PROTECTION.
We are required to ensure the privacy of your medical information. We must follow the terms of the following information and provide you with a copy. If there are any changes to this notice, a revised notice will be provided upon request.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU:

For Treatment: For example, a nurse providing you care will report any changes in your condition to the doctor
For Payment: For example, we may need to give your insurance plan information about your diagnosis, treatment or supplies used.
For Health Care Operations: For example, we may use your medical information to evaluate our services. We may contact you at the phone number or address you have provided to us in order to remind you of an appointment, obtain payment or for other health care matters.

We may use/disclose your medical information to let you know of treatment alternatives or other health related benefits/services. We may disclose your medical information to family members, friends, or others who are involved in your care or payment for your care. You must notify us (our Designee) in writing if you do not want us to communicate with you in any of these ways.

We may use your medical information for uses that are required or permitted by law. Other uses and disclosures will only occur with your written authorization. You may cancel an authorization at any time by notifying us (our Designee) in writing.

You additionally have the following rights: **Right to privacy notice; Right to request restrictions on uses and disclosures of your medical information; Right to receive confidential communications; Right to inspect and copy your medical information; Right to request an amendment to your medical information; and Right to an accounting of disclosures of your medical information.**

Contact Information: If you feel your privacy rights have been violated, please contact our Designee at 717-832-5993, or file a complaint with the Secretary of the Department of Health and Human Services.

My signature below indicates that I hereby acknowledge the receipt and understanding of the **Summary Notice of Privacy Practices**.

____ ______________________
Signature of Patient or Personal Representative Date

____ ______________________
Printed Name of Patient or Personal Representative Printed Name of Minor

Relation to Minor:______________________________