Notice of Privacy Practices

Compass Point

DR. Yezerski

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about your treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The practice provides this form to comply with the Health Insurance Portability and Accountability act of 1996 (HIPAA).

You understand that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- We have a Notice of Privacy Practices and you have the opportunity to review this Notice.
- We reserve the right to change the Notice of Privacy Policies.
- You have the right to restrict the use of your information but the Practice does not have to agree to those restrictions.
- You may revoke the Consent in writing at any time and all future disclosures will then cease.
- We may condition treatment upon the execution of this Consent
- Excuses for work or school are to be given or faxed to the patient.
- Your information may need to be faxed to a physician or dentist.
- We may sometimes call and leave messages concerning appointments.

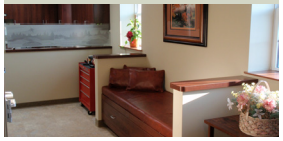
This consent was signed by _____ Date _____

Relationship to Patient (if other than patient) _____ Date _____

We request that you supply us with the names of two individuals whom you authorize us to speak with regarding your personal health care information if it becomes necessary.

Name _____ Phone _____

Name _____ Phone _____



7379 Pearl Road, Middleburg Heights, Ohio 44130
p.440-234-1810

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