NOTICE OF PRIVACY POLICY

Effective December 1, 2009

The following is the privacy policy of Patricia Arledge M.D. PLLC ("Covered Entity") as described in the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated there under, commonly known as HIPAA. HIPAA requires Covered Entity by law to maintain the privacy of your personal health information and to provide you with notice of Covered Entity's legal duties and privacy policies with respect to your personal health information. We are requiring by law to abide by the terms of this Privacy Notice. Generally, we may not use or disclose your personal health information without your permission. Further, once your permission has been obtained, we must use or disclose your personal health information in accordance with the specific terms that permission.

You may obtain a full policy at any time during regular business hours at

3502 9th Street Suite 270 Lubbock, TX 79415

CONSENT FOR USE, DISCLOSURE OR PROTECTED HEALTH INFORMATIONS FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

I understand that as part of my health care, Dr. Arledge's office originates and maintains medical records describing my health history, symptoms, examination and test results, diagnoses, treatment, financial and demographic information as well as any plans for future care or treatment. Dr. Arledge's office also originates and maintains billing records. I understand and consent to this information being used and disclosed for the following purposes:

- Planning my care and treatment
- Communications between Dr. Arledge's office and health care professionals that act under the direction of Dr. Arledge and participants in her diagnosis, and evaluation of treatment
- Collection of fees for medical service
- Determining liability for payment and obtaining reimbursement
- Conducting healthcare operations, including: the evaluation of health care services, appropriateness and quality of health care treatment and qualifications of the health care practitioners

I have been provided with a copy of Dr. Arledge's *Notice of Privacy Policy* that provides information about how Dr. Arledge uses and discloses Protected Health Information about me. I understand I have the following rights and privileges:

- The right to review the Notice prior to signing this consent
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations. Dr. Arledge is not required to agree to requested restrictions, but is bound to any restrictions agreed to.
- I understand that as provide in the *Notice of Privacy Policy*, the terms of the *Notice* may change.

_____ _____ _____

Signature Witness Date

ACKNOWLEDGEMENTS AND AGREEMENTS

I realize that in my assignment of insurance benefits I am not released from my responsibility for all charges related to services rendered to me by **Patricia R Arledge M.D. PLLC**

I authorize **Dr. Patricia R. Arledge M.D. PLLC** to release any medical information regarding services preformed to my insurance company, or personal physician.

I herby authorize my insurance company to pay any and all benefits due to me as described in my policy contract directly to **Dr. Patricia R Arledge M.D. PLLC**

A photographic copy of this authorization is as valid as the original. This is valid indefinitely.

_____ _____ _____

Signature Witness Date

PHOTOGRAPHIC CONSENT

I hereby give permission to **Patricia R Arledge M.D. PLLC** to take necessary clinical photographs of me with the understanding that such photographs are for clinical and advertorial purpose. All photographs will remain property of **Dr. Arledge** and her staff.

_____ _____ _____

Signature Witness Date

I wish to restrict my health information to:

_____

_____

_____

_____

I allow the following to have access to my health information:

_____ Relation:_____

_____ Relation:_____

_____ Relation:_____

_____ Relation:_____

_____ _____ _____

Signature Witness Date