



Robin A. Sykes, M.D.
2055 Military Trail, Suite 305
Jupiter, FL 33458

RECEIPT OF NOTICE OF PRIVACY PRACTICE WRITTEN ACKNOWLEDGEMENT FORM

How we may use and disclose medical information about you:

For treatment, payment, health care operations, appointment reminders, treatment alternatives, health-related benefits and services, facility directory, individuals involved in your care of payment for your care, research, as required by law, or to prevent a serious threat to health or safety.

Special Situations:

Organ and tissue donation, Worker's Compensation, public health risks, health oversight activities, lawsuits and disputes, law enforcement, coroners, medical examiners and funeral directors, national security and-intelligence activities, protective services for the President and others, inmates.

Your rights regarding medical information about you:

You have the following rights regarding medical information we maintain about you:

The right to inspect and copy, the right to amend, the right to an accounting of disclosures, the right to request restrictions, the right to request confidential communications, the right to a copy of our unabridged Notice of Privacy Policy.

Changes to this notice:

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice. The notice will contain on the last page, in the bottom left-hand corner, the effective date. In addition, each time you come in for services, you will be offered a copy of the current notice in effect.

Complaints:

If you believe any of your privacy rights have been violated, you may file a complaint with the district or with the US Dept. of Health and Human Services. For addresses, please contact our Compliance Officer. All complaints must be submitted in writing.

You will not be penalized for filling a complaint.

Other uses of medical information:

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us with permission to use or disclose medical information about you, you may revoke that permission in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

If you have questions about individual items listed above, please request a copy of our complete Notice of Privacy Policy.

1. _____, have received a summary of Dr. Robin Sykes Notice of Privacy Policy.

Signature of patient or legal guardian

Date