Office of Lindsay Keith, M.D.
615-900-2621 | LindsayKeith.com
1830 Heritage Park Plaza Murfreesboro, TN 37129

HIPAA NOTICE OF PRIVACY PRACTICES

PATIENT NAME: ______________________________ DOB: ________________

I understand that my health information is private and confidential. I understand that the office of Dr. Lindsay Keith, PLLC, works very hard to protect my privacy and preserve the confidentiality of my personal health information.

I understand that signing this document means that the office of Dr. Lindsay Keith, MD, PLLC may use and disclose personal health information to help provide health care to me, to handle billing and payments, and take care of other health care operations. Failure to sign this consent may result in the physician declining to treat me.

The office of Dr. Lindsay Keith, M.D. PLLC may update this Notice of Privacy Practices. If I ask, Dr. Lindsay Keith, M.D. PLLC will provide me with the most current Notice of Privacy Practices.

Under the terms of this consent, I can ask Dr. Lindsay Keith, M.D. PLLC, to restrict how my personal health information is used and disclosed to carry out treatment, payment, or health care operations. I understand that Dr. Lindsay Keith M.D. PLLC does not have to agree with my request. If Dr. Lindsay Keith, M.D. PLLC does agree to my request, I understand they will follow the agreed limits.

I understand that I have the right to cancel this consent in writing, at any time. If I do cancel this consent, I understand that Dr. Lindsay Keith, M.D., PLLC may have already used or disclosed information about me, and canceling this consent would not affect the information already used or disclosed.

IMPORTANT: To obtain your copy of the "NOTICE OF PRIVACY PRACTICES," please request it from the front desk.

Please check one of the following:

☐ I have taken a HIPAA Notice of Privacy Practices for my records.

☐ I have been offered a Notice of Privacy Practices but declined to take one with me.

SIGNATURE: ____

PHONE: ____