The Right To Obtain A Paper Copy Of This Notice.

The practice will provide you a separate paper copy of this notice upon request if you have already seen a copy or if you have agreed to review it electronically.

VII The Practice's Duties

The practice is required to insure the privacy of your healthcare information, to provide you with this notice of your rights, and the practices duties and procedures regarding your privacy. The practice must abide by the terms of this notice as may be amended periodically. The practice reserves the right to change the terms of this notice and to make the new notice provisions effective for all protected healthcare information that the practice collects and maintains. If the practice alters this notice, the practice will provide a copy of the revised notice through regular mail or in person contact at the time of an appointment.

VIII Complaints

If you believe that your privacy rights have been violated, you have the right to relate complaints to the practice and to the secretary of the Department of Health and Human Services. You may provide complaints to The practice verbally or in writing. Such complaints should be directed to the privacy officer of the practice. The practice encourages you to relate any concerns that you have regarding the privacy of your information and you will not be retaliated against in any way for filing a complaint.

IX Contact Person

The practices contact person regarding the practices duties and your rights under the HIPAA privacy regulations is known as the privacy officer. The privacy officer can provide Information regarding issues related to this notice by request. Complaints to the practice should be directed to the privacy officer at the following address:

Generations
Stephanie Penrose MD
Liza Freehling NP
Paige Hendrix NP
11175 E Mississippi Ave, Suite 210
Aurora CO 80012-3137

The privacy officer can be contacted by telephone at 303-797-7227 during normal business hours.

Effective Date.
This notice is effective as of April 14, 2003.

_____ _____ / _____ / _____
Patient signature Date

My signature above designates that I have read and understand my rights under the HIPAA regulations and will contact the privacy officer for any of my concerns.