

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Practice Name:	Dive Well Medical Services
Provider:	Christopher Allen, MD
Address:	
Phone:	
Effective Date:	<u>4/30/2026</u>

OUR COMMITMENT TO YOUR PRIVACY

We are committed to protecting your medical information. We create a record of the care and services you receive to provide quality care and to comply with certain legal requirements. This notice applies to all records of your care generated by this practice.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways we use and disclose medical information. Not every use or disclosure in a category will be listed. However, all the ways we are permitted to use and disclose information will fall within one of the categories.

Uses and Disclosures We May Make Without Your Written Authorization:

1. Treatment

We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, or other practice personnel who are involved in taking care of you. We may share with outside lab or radiology companies to order needed services

2. Payment

We may use and disclose medical information about you so we can bill and collect payment from you, an insurance company, or a third party. For example, we may share information about the services you received with your health plan to get paid for those services.

3. Health Care Operations

We may use and disclose medical information about you for health care operations, which are necessary to run our practice and make sure all of our patients receive quality care. For example, we may use your medical information to review our treatment and services and to evaluate the performance of our staff.

4. Appointment Reminders

We may use and disclose medical information to contact you with reminders about your appointments. For example, we may leave a message on your answering machine or with a household member confirming your appointment.

5. Treatment Alternatives and Health-Related Benefits

We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you, or about health-related benefits or services that may be of interest to you.

6. As Required by Law

We will disclose medical information about you when required to do so by federal, state, or local law. This includes disclosures for public health activities, reporting abuse or neglect, health oversight activities, law enforcement, court proceedings, and national security purposes.

7. Business Associates

We may share your information with third-party 'business associates' who perform services on our behalf, such as billing companies, IT vendors, or transcription services. We require our business associates to protect the privacy of your information appropriately.

USES AND DISCLOSURES REQUIRING YOUR WRITTEN AUTHORIZATION

We will obtain your written authorization before using or disclosing your protected health information for purposes not described in this notice, including:

- Uses and disclosures of protected health information for marketing purposes
- Disclosures that constitute a sale of protected health information
- Other uses and disclosures not described in this notice

You may revoke your authorization at any time, in writing, except where we have already acted in reliance on the authorization.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

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

Right to Inspect and Copy

You have the right to inspect and copy medical information that may be used to make decisions about your care, including medical and billing records. To inspect and copy this information, you must submit a written request to our Privacy Officer. We may charge a fee for the cost of copying, mailing, or other supplies.

Right to Amend

If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend it. You have the right to request an amendment for as long as we keep the information. Your request must be in writing and include a reason for the request.

Right to an Accounting of Disclosures

You have the right to request an 'accounting of disclosures' — a list of disclosures we made of your medical information for certain purposes other than treatment, payment, and health care operations. This right applies to disclosures made in the six years prior to your request.

Right to Request Restrictions

You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your protected health information to a health plan for payment or health care operations purposes and the information pertains solely to a health care item or service for which you have paid out of pocket in full.

Right to Request Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we contact you at work instead of at home. We will accommodate all reasonable requests.

Right to a Copy of This Notice

You have the right to a paper copy of this notice at any time. You may also obtain a copy of this notice on our website, if we maintain one.

Right to Notification of a Breach

You have the right to be notified following a breach of your unsecured protected health information.

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 in our office. The notice will contain the effective date on the first page.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with our practice, contact our Privacy Officer at the address below. You will not be penalized for filing a complaint.

U.S. Department of Health and Human Services – Office for Civil Rights:

200 Independence Ave S.W., Washington, D.C. 20201 | Phone: 1-800-368-1019 | Website: www.hhs.gov/ocr/privacy

PATIENT ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I have received a copy of [Practice Name]'s Notice of Privacy Practices.

Patient Signature

Date

Signature

Date Signed

Patient Printed Name

Print Name