



Notice of Privacy Practices & HIPAA Acknowledgment

Your Rights as a Patient

As a patient receiving care at KR Myology, you have the right to:

- Access and request a copy of your medical records.
- Request corrections to your health records if you believe they contain errors.
- Request limits on how your information is used or disclosed.
- Request confidential communication (e.g., use of specific phone numbers or addresses).
- Obtain a list of certain disclosures of your health information.
- File a complaint if you believe your privacy rights have been violated.

How We May Use and Disclose Your Health Information

We may use or share your health information to:

- Provide and coordinate care, including communication with referring providers.
- Process payments and manage billing (e.g., creating superbills).
- Conduct healthcare operations, such as quality assurance and administrative audits.
- Comply with legal and public health obligations, including reporting abuse or threats to safety.
- Communicate appointment reminders, session updates, or administrative matters.
- Share information with others involved in your care with your verbal or written permission.
- We will not sell your information or share it for marketing without your explicit written authorization.

Your Consent

By signing this form, you acknowledge:

- You have received and reviewed this Notice of Privacy Practices.
- You understand that your health information may be used for the purposes described above.
- You have the right to revoke this consent in writing at any time.

Myofunctional Therapy Specifics

Because myofunctional therapy often involves behavioral tracking, facial/muscle observation, and photo/video documentation for progress monitoring, the following may also apply:

- Images, videos, or intraoral photos may be used strictly for clinical documentation, patient education, or case coordination.
- No identifying information or images will be shared externally without your written release.

I have read and understand the Notice of Privacy Practices for KR Myology. I consent to the use and disclosure of my protected health information as outlined above.

Name: _____ Date: _____

Parent/Patient Signature: _____

Witness: _____