



## NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

### OUR LEGAL DUTY

- We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect January 1, 2014, and will remain in effect until we replace it.
- We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.
- You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

**USES/DISCLOSURES OF HEALTH INFORMATION** We may use and disclose health information about you for treatment, payment, and healthcare operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review.
- **Healthcare Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

### PATIENT RIGHTS

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

- **Access:** You have the right to inspect and copy your protected health information.
- **Restriction:** You have the right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- **Alternative Communication:** You have the right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- **Amendment:** You have the right to request that we amend your protected health information. Your request must be in writing and it must explain why the information should be amended. We may deny your request under certain circumstances.
- **Disclosure Accounting:** You have the right to receive an accounting of disclosures of protected health information.
- **Electronic Notice:** If you receive this Notice on our website or by electronic mail, you are entitled to obtain a paper copy of this Notice upon request.

### Questions and Complaints

If you want more information about our privacy practices, please contact us. You have recourse if you feel that we have violated your privacy rights. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

## **CONSENT TO THE USE AND DISCLOSURE OF CONFIDENTIAL HEALTH INFORMATION**

By signing this document, you convey that you understand that as part of your health care, we originate and maintain health records describing your health history, symptoms, examinations, diagnoses, treatment, and any plans for future care or treatment. You also understand that this confidential health information will not be shared with anyone who does not require it. Your information will not be used for any other purposes other than what is specified in our **Notice of Privacy Practices** unless we have asked for and have been given your permission. We reserve the right to change our notice and privacy practices and prior to implementation will provide you with a copy.

### **Your health information will be used:**

1. **To provide treatment:** We will use your health information within our office to provide you with the best health care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between the practitioner and office staff. We may share your health information, when appropriate, with referring physicians, clinical and pathology laboratories or other health care personnel providing your treatment.
2. **To obtain payment:** We will use your health information with an invoice to collect payment for treatment you received in this office. We may do this with insurance forms filed for you in the mail.
3. **To conduct healthcare operations:** We will use your health information for such operations as verifying to a third party payer that services billed were actually provided, or assessing quality, or reviewing the competence of healthcare professionals.

### **You have the right to:**

1. **Inspect and copy your health information:** You have the right to read, review and copy your health information, including your chart and billing records. If you would like a copy of your health information, please let us know. We may need to charge you to duplicate and assemble your copy.
2. **Amend your health information:** You have the right to ask us to update or modify your records if you believe they are incorrect or incomplete. We will accommodate you as long as our office maintains this information. Please make your request in writing and inform us of the reason for the change in detail. Your request may be denied if the health information requested was not created by our office, is not part of our records or if the records pertaining to your health information are determined to be accurate and complete.
3. **Documentation of your health information:** You have the right to ask for a description of how and where your health information was used by our office for any reason other than treatment or payment or health care operations. We will be able to provide you a copy of your health information upon request, as long as it is not 7 years or older.

**You have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. You have read the Notice of Privacy Practices, have had the opportunity to ask questions regarding its content and meaning and fully understand its content and implication.**

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operation and that the organization is not required to agree to the restrictions. I further understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. You acknowledge that you have read and agree to all of the above:

Patient's Name: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(or patient's representative and relationship if signing for patient)