

Notice of privacy practices

This notice describes how your health information may be used and how you can gain access to this information. **Please review it carefully.**

The HIPPA (Health Insurance Portability and Accountability) Act requires us to maintain the privacy of your health information, and to inform you about our privacy practices. This law was written to protect the confidentiality of your health information. You may request a copy of our privacy notice at any time by simply asking the front office staff or your doctor.

HOW YOUR HEALTH INFORMATION MAY BE USED:

- **To provide treatment**
Within our office your health information will be used to provide you the best care and services possible. This may include communication between you and office personnel to optimize scheduling and completion of clinical procedures. In addition, we may share this information with referring physicians, clinical pathology laboratories, or other health professionals providing you treatment.
- **To conduct health care operations**
Your doctor may discuss your case and/or x-rays with another doctor, student, intern, associate, as well as business/clinical employees of the practice. This is for the sole purpose of training and education. It is also possible that your health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may also be reviewed during the routine certification, licensing, and credentialing processes.
- **To obtain payment**
Your health information may be included with paperwork submitted for the purpose of collecting payment for services provided to you in this office.
- **In patient reminders**
Because we believe regular care is important to your health, we will remind you of scheduled appointments, or the need for you to contact our office. These reminders may include but are not limited to phone calls, postcards, newsletters, flyers, email, or voice messages.
- **To fulfill public health/national security obligations**
We may be required to disclose your health information to report problems related to public health or national security such as disease/infection exposure to prevent or control disease, injury, and/or disability to others.
- **As required by law**
We may be required by law to disclose your health information to the proper authorities for the purpose of law enforcement, such as if you are the victim of a crime, abuse, neglect, domestic violence, or other criminal acts.
- **To designated family/emergency contacts/caregivers**
We may share your health information with a family member or other person responsible for your care in the event of an emergency. In such emergent situations, if you are unable to communicate your wishes, we will use our best judgment when sharing your health information with others involved with your care.

*** Other than what is stated above, or where federal, state, or local law requires, we will not disclose your health information other than with your written authorization. You may revoke this authorization in writing at any time.*

YOUR PRIVACY RIGHTS AS A PATIENT:

- **Confidential communications**
You have the right to request that we communicate with you in a specific way. You may request that we only communicate your health information to you privately, with/without family or caregivers present, or through sealed mail communications. We will make every effort to honor all reasonable requests.
- **Access to your health information**
You have the right to read, review, and copy any of your health information, including your children's. If you would like to have a copy of your records, please let us know in writing. This service may require a small fee and a reasonable amount of time to complete.
- **Amendment of your health information**
You have the right to ask us to update or modify your records if you believe your health information is incorrect or incomplete. Your request must be in writing, and include an explanation of why the information should be amended. The request may be denied under certain circumstances including, but not limited to the following; the information was not originally created by our office, is not part of our records, or if the records have been requested to be sealed and delivered to authorities for review.
- **Restrictions**
You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these requests, but if we do, we will abide by our agreement (except in the case of an emergency). These requests must be in writing. You may discuss this further with the front office staff or your doctor.

You have the right to request a copy of our office's notice of privacy practices form at any time. We are required by law to maintain the privacy of your health information and to provide you and/or your caregiver our privacy practices information. We are required to practice the policies and procedures described in this notice, but we do reserve the right to change the terms of this policy, and patients will be notified in the event of any such changes. In the case that you believe your privacy rights have been compromised, you have the right to express your concerns with us or with the Secretary of Health and Human Services.

Thank you for taking the time to review how we carefully protect your private health information. If you have any questions or concerns, please do not hesitate in asking for clarification. We appreciate that you acknowledge having read through, understand and received this policy.

PATIENT ACKNOWLEDGMENT:

Patient Name: _____

Patient Signature: _____ Date: _____

If you are a minor, or if another party is representing you, this notice must be acknowledged by the party authorized to act on your behalf.

Name of Representative: _____

Relationship to Patient: _____

Representative Signature: _____ Date: _____