

## HIPPA NOTICE OF PRIVACY PRACTICES

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health services.

**Uses and Disclosures of Protected Health Information:** Your PHI may be used and disclosed by your physician, our office staff and others outside of your office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health office care bills, to support the operation of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your PHI to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party.

**Payment:** Your PHI will be used, as needed, to obtain payment for your health care services.

**Healthcare Operations:** We may use or disclose, as needed, you PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may use a sign-in sheet at the front desk, or we may call you by your name in the waiting area. We may use or disclose you PHI, as necessary, to contact you for your appointments.

We may use or disclose you PHI in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Disease: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceeding: Law Enforcement: Coroners, Funeral Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

**Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object** unless required by law.

**You may revoke this authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action to reliance on the user or disclosure indicated in the authorization.

**Your Rights:** Following is a statement of your rights with the respect of your PHI.

**-You have the right to inspect and copy your PHI.**

**-You have the right to request a restriction of your PHI**

**-You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us.**

**-You may have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

**Complaints:** You may complain to us or to the Secretary of Health and Human Services if you believe we have violated your privacy rights by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and became effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to your PHI. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone.

**Signature below is an acknowledgement that you have received this Notice of our Privacy Practices:**

Signature: \_\_\_\_\_ Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Please list person(s) who we may discuss your treatment or financial account with**