

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This Notice is effective March 1, 2013 and applies to all protected health information as defined by federal and state regulations. (Rev. 9/2020)

<p><b>Understanding your health record/ information:</b> What is in your healthcare record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and for you to make better informed decisions when authorizing disclosure to others.</p> <p>Each time you visit our office a record of your visit is made. This record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, referred to as your health or medical record may be used by our practice as follows:</p> <ul style="list-style-type: none"> <li>• A basis for planning your care and treatment</li> <li>• A means of communication among health professionals who contribute to your care. We may need to transmit PHI over an unsecured medium, such as the internet, or text message when deemed necessary by the healthcare provider.</li> <li>• A legal document describing the care we provided to you</li> <li>• A record that you or a third-party payer can verify services billed were actually provided</li> <li>• A tool in educating health professionals</li> <li>• A source of data for medical research</li> <li>• A source of information for public health officials charged with improving the health of this county, state and the nation</li> <li>• A tool which we can assess and continually work to improve the care we render and the outcomes we achieve</li> <li>• To provide you with information on additional treatment alternatives and other health related benefits</li> <li>• We may use your information for appointment reminders as defined by the "Consent" page</li> <li>• Your Health Information Rights: Although your health record is the physical property of this practice, the information belongs to you. You have the right to:             <ul style="list-style-type: none"> <li>• Obtain a copy of this "Notice of Patient Information Privacy Practices"</li> <li>• Inspect and/or receive a copy your health record electronically as provided for in 45 CFR 164.512 and 45 CFR 164.524 (HIPAA)</li> <li>• Amend your health record as provided in 45 CFR 164.524 (HIPAA)</li> <li>• Obtain an accounting of disclosures of your health information</li> <li>• Request communications of your health information by alternative means or at alternative locations</li> <li>• Request a restriction on certain uses and disclosures of your information to health plans, if you fully paid for these services out of pocket</li> <li>• Revoke your authorization to use or disclose health information except to the extent that action has already been taken</li> </ul> </li> <li>• You have a right to opt out of communications for fund raising activities of this practice</li> </ul>	<p><b>Our Responsibilities, we are required to:</b></p> <ul style="list-style-type: none"> <li>• Maintain the privacy of your health information as defined by federal/state laws</li> <li>• Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you</li> <li>• Notify you of a breach of your protected healthcare information</li> <li>• Notify you if we are unable to agree to a requested restriction</li> </ul> <p>We reserve the right to change our privacy practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post the changes in our reception area. At your request, we will provide you a revised "Notice of Patient Privacy Practices".</p> <p><b>To Report a Problem</b> If you have questions, would like additional information, or wish to report a problem, please contact the practice's Privacy Officer.</p> <p>If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint.</p> <p><b>Treatment, Payment and Health Operations:</b> Treatment: Information obtained by a member of our healthcare team will be recorded in your record and will be used to determine the course of treatment we believe is best for you. We may also share with others involved with your treatment copies of your healthcare information to assist them in treating you.</p> <p><b>Payment:</b> A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.</p> <p><b>Healthcare Operations:</b> Members of the medical staff may use information in your health record to assess the care and outcomes in your case and others like it. This information may be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.</p> <p><b>Business Associates:</b> There are some services provided to our organization through contracts with business associates. When these services are contracted, we may need to disclose your health information to our business associate/s so they can perform the job we've hired them to do. HIPAA now requires the representatives to sign a "Business Associate Agreement" protecting and securing your health information as required by Federal and State law</p>	<p><b>Notification:</b> We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition. (As governed by federal/state law and the "Consent" page)</p> <p><b>Communication with family:</b> Our healthcare professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care. as governed by federal/state law.</p> <p><b>Research:</b> We may disclose information to researchers, when an institutional review board having reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research. This information will be de-identified.</p> <p><b>Food and Drug Administration (FDA):</b> We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.</p> <p><b>Workers Compensation:</b> We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.</p> <p><b>Public health:</b> As required by law we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.</p> <p><b>Correctional institution:</b> Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.</p> <p><b>Law enforcement:</b> We may use or disclose your PHI as required by law or required by a court ordered subpoena.</p> <p><b>Abuse and Domestic Violence:</b> As provided by federal and state law, we may, at our professional discretion, disclose to proper federal or state authorities healthcare information related to possible or known abuse or domestic violence.</p> <p><b>Authorization:</b> We will not use or disclose your health information without written authorization from you or your legal representative for: psychotherapy notes, HIV+/AIDS status, drug/ alcohol abuse records, marketing purposes, disclosures that constitute the sale of your PHI, or other uses and disclosures not described in this notice.</p>
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## PATIENT CONSENT FOR USE, DISCLOSURE OR REQUEST OF HEALTH INFORMATION FOR TREATMENT OR PAYMENT

Patient Name: \_\_\_\_\_

As part of your healthcare, this practice originates and maintains paper and/or electronic records describing your health history, symptoms, examinations, test results, diagnoses, treatment, any plans for future care or treatment and payment for services information. We use this information to:

- Plan your care and treatment
- Communicate with other health professionals who contribute to your healthcare
- Submit your diagnosis and treatment information for payment from insurance companies or others

### **“ONLY AS PERMITTED BY STATE OR FEDERAL LAW”, you are giving this practice CONSENT to do the following:**

- To disclose, as may be necessary, your protected health information (including HIV+/AIDS status, drug/alcohol abuse notes and qualified mental health notes) to other healthcare providers (such as: referrals to or consultation with, other healthcare professionals, laboratories, hospitals, etc.) for your treatment and/or healthcare.
- To request from other healthcare entities (i.e. doctors, dentists, hospitals, labs, imaging centers, etc.) specific healthcare information we may need for planning your care and treatment.
- To submit the necessary information to your insurance company(s) for coverage verification as well as the diagnosis and treatment information to insurance company/s, other agencies and/or individual(s) for payment of our services.
- To leave appointment reminders or information we believe necessary for your treatment or payment on your answering machine or with a member of your household. The information will be the minimum necessary in our professional judgment.
- To discuss your health or payment information (only the minimum necessary in our judgment) with family members or other persons who are or may be involved with your healthcare treatment or payments.
- If you choose, please list by name and relationship of persons with whom we may share your healthcare or payment information \_\_\_\_\_
- You may request a copy of or as a new patient, will be given a copy of our **“Notice of Patient Privacy Practices”** that provides a more complete description of health information uses and disclosures as required by the HIPAA standard. You have read or have had the right to read the **“Notice of Patent Privacy Practices”** prior to signing this consent.

**I fully understand and agree to this consent and acknowledge the above rights and disclosures.**

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Signature (Patient or Guardian):** \_\_\_\_\_ **Date:** \_\_\_\_\_

(Parent or legal guardian if patient is under age 18 or unable to authorize consent. If you are not the parent, please provide a copy of your legal authority for this patient. RELATIONSHIP \_\_\_\_\_)

### **FOR OFFICE USE ONLY**

Patient refuses to sign acknowledgement of Notice of Privacy Practices.

**Staff Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

(Parent or legal guardian if patient is under age 18 or unable to authorize consent.)