Notice of Health Information Privacy Practices

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.

Introduction

This practice is committed to treating and using protected health information about you responsibly. This **Notice of Health Information Practices** describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 1, 2003 and applies to all protected health information as defined by federal and state regulations.

Understanding Your Health Record/Information

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, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating heath professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing, with your authorization,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your 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 make more informed decisions when authorizing disclosure to others.

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:

- Obtain a paper copy of this "Notice of Information Privacy Practices" upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,

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- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

We are required to:
- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our 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 and expense, we will provide a revised "Notice of Patient Privacy Practices" to the address you've supplied us.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If you have questions, would like additional information or wish to report a problem, please contact the practice's Privacy Officer so we help you. We will take all reasonable steps to see that your concerns are addressed.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this practice originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the health professionals who contribute to my care, i.e. consultations & referrals
- A source of information for applying my diagnosis and treatment information to my bill, for payment purposes
- A tool for routine healthcare operations, such as assessing quality and reviewing the competence of staff

I have been provided the opportunity to review the *"Patient Privacy Practices"* that provides a more complete description of information uses and disclosures. I understand that I have the following rights:

- The right to review the ***"Patient Privacy Practices"*** prior to acknowledging this consent
- The right to restrict or revoke the use or disclosure of my health information for purposes other than treatment or payment
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

Restrictions:

I request the following restrictions to the use or disclosure of my health information:

_____

_____

If there is anyone you do not want us to discuss your healthcare information with, please list their names and relationship below

_____

_____

Messages or Appointment Reminders:

If you do not want us to leave a message on your answering machine or with someone at your home reminding you of an appointment, which may also include non-sensitive healthcare information, please check the box below.

Do not leave a message on my answering machine or with anyone at my home [ ]

I understand that as part of treatment, payment, or healthcare operations, it may become necessary to disclose health information to another entity, i.e., referrals to other healthcare providers, labs, and/or other individuals or agencies as permitted or required by state or federal law.

I fully understand the information provided by this consent.

_____	_____	_____
Signature	Print name of person signing	Date

*If other than patient is signing, are you the parent, legal guardian, custodian or have Power of Attorney for this patient, for treatment, payment or healthcare operations. Yes [ ] No [ ]

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[ ] Patient refused to sign the consent form.

[ ] Reason for patient refusal to sign_____

[ ] Restrictions were added by the patient (see restrictions listed above)

[ ] " Consent form" received and reviewed by_____ on (date) _____