HIPAA Patient Privacy Notice

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies labeled **'Notice of Privacy Practices'** in the reception area.

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- open treating area means open discussion. If you need to speak privately to the doctor please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source
4. For workers compensation or personal injury purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. For public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public
7. To government agencies or law enforcement – to identify or locate a suspect, fugitive, material witness or missing person
8. For military, national security, prisoner and government benefits purposes
9. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death
10. Telephone calls or emails and appointment reminders -**we may call your home and leave messages** regarding a missed appointment or inform you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice was ever sold the new owners would have access to your personal health information.

YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request restrictions on certain uses and disclosures and with whom we release information to although we are not required to comply. If however we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance
6. To request amendments to information, however like restrictions we are not required to agree to them.
7. To obtain one copy of your records at no charge, when timely notice is provided (72 hours). X-rays are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center to have copies made we will be happy to accommodate you however you will be responsible for this cost.

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information please contact our office directly. If you are still not satisfied with the manner in which this office handles your complaint you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

I have received a copy of the Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Patient Privacy Policy" at a time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and copies are available in the reception area. At this time I do not have any questions regarding my rights or any of the information I have received.

I would like to add this personal contact as a recipient of my health information if the situation should arise:

______________________________	______________________________	______________________________
Contact Name	Relationship to patient	Contact Number
______________________________	______________________________	______________________________
Patient Signature	Patient Name (PRINT)	Date
______________________________	______________________________	______________________________
Witness Signature	Witness Name (Print)	Date