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ourfamilydoctor

NOTICE or Parvacv rnacrrcas

This notice describes how your personal hcalthcarc information may be disclosed or used by this office. Please read this notice carefully. If you have any questions. please contact our Privacy l'Llfiiccr+ After reviewing this document, you will be asked to sign that you have received this notice+

This office is required to abide by the terms of the Notice of Privacy Practices. The terms may change at any time and the revised notice will apply to all protected health information maintained at that time. You may request a revised copy of this notice by calling our office.

This office has taken reasonable steps to safeguard the privacy and confidentiality of your Protected Health Information {PHI}. The staff of the office will only use your health information for the intended patient care purpose. Conversations among staff members that reference your infomration will be conducted in a confidential and professional manner.

I. USES AND DISCLOSURES OF PROTEC'I'ED HEALTH INFORMATION FOR TPO

This office will need to access your protected health information for purposes of treatment, payment and operations (TFO) in accordance with state and federal law.

A. USING l5: DISCLOSING INFORII'IATION FOR TREATMENT PL'RPOSES

To maintain high quality healthcarc, it will be necessary to share protected health information with all members of your treatment team. This can include employees in this office as well as other providers.

B. USING & DISCLOSING INFORMATION FOR PAYMENT PURPOSES

Necessary information will be shared with appropriate payer sources and their representatives for payment purposes including, but not limited to eligibility, benefit determination, and utilization review. it will also be necessary for our intemal billing personnel to have access to protected health information to carry out their job functions.

C. USING 8c DISCLOSING INFORMATION FOR OPERATIONS PURPOSES

Necessary information will he shared for the continuing operations of this office. Some examples include, but are not litnitcd to peer review, accreditation, and compliance with all federal and state laws.

I. SPECIFIC AUTHORIZATION RE IIIRED FOR OTHER IISES AND DISCLOSURES

Other uses and disclosures of your protected health information will only be made with your written authorization. This authorization will only allow the use or disclosure of the specific information detailed on the authorization form. Some examples include, but are not limited to: some marketing activities, the use or disclosure of psychotherapy records in our possession, and in some instances for research purposes.

3. OTHER USES AND DISCLOSURES "'ITHOII'I' YOL'R AUTHORIZATION

The following are situations where this office may disclose your PHI without your consent or authorization.

s. Uses and disclosures of PHI as required by law, court orders, government agencies, or a legal process.
B. Uses and disclosures of PHI for matters of public health for the purpose of controlling disease as dictated by law.
C. Uses and disclosures may be made to public health authorities in situations of suspected abuse or neglect.
D. Uses and disclosures to institutional ras'iew boards for the purpose of medical research.
E. Uses and disclosures to government overslght agencies for the purpose of health and privacy audits or investigations.

4. PATIENT PRIVACY RIGHTS EFFECTI'VE APRIL 14, 2003

In general, you will have the right to review and copy your PHI as well as amend your record. Some exceptions include, but are not limited to: psychotherapy notes, information compiled for use in a civil, criminal, or administrative proceeding.

You have the right to request a restriction of the disclosure of your PHI for treatment, payment, or

operations. This office is not rmruired to agree to the request, but will do so at our discretion.

You have the right to request to receive confidential communications from us by altemative means or to an alternative location. We will make every effort to honor reasonable requests.

You have the right to request an accounting of the disclosures made of your PHI by this of ficc {after CW] 4f2t'ttl3). This only applies to disclosures made for purposes other than treatment, payment, or operations.

5. PRIVACY OFFICER E: CUMPLAINTS

Should you have any concerns you may contact our Privacy Officer who is responsible for the privacy and confidentiality of your information in accordance with state and federal law. Any complaints or issues you have regarding the privacy or confidentiality of your information should be directed to the privacy officer.

l'vty signature below indicates that l have received a copy of this “NOTICE OF PRIVACY PRACTICES" and that if I have any questions regarding this notice, I can discuss it with the designated Privacy |Officer.

Patient Signature **I**

CONSENT FOR USE AND DISCLOSURE DF INFDRIMATIUN

l have reviewed the “NU'I‘ICE DP PRlvACY PRACTICES" of ourfarnilydoctor and have had all questions answered by this office.

I also consent to the use or disclosure ofmy PHI for the following purposes:

TREATMENT '

it will be necessary to share Pill with all members of the treatment team for treatment purposes. This can include employees in this office as well as other providers.

PAWIENT

Necessary information will be shared with appropriate payer sources and their representatives for payment purposes including, but not limited to eligibility, benefit determination, and utilization review. It will also be necessary for our billing personnel, including btlt not limited to employees, case managers, claints representatives, third party billing services, or clcaringhouses to have access to PHI to carry out their job Functions.

HEAL'I'l-ICARE. UPERA'I'IUNS

Necessary information will be shared for the continuing operations of this office. Some examples include, but are not limited to peer review, accreditation, credentialing processes, and compliance will all federal and state laws.

[understand that my treatment may be conditioned upon my consent. This consent is given freely and I understand that I can revoke this consent at any time in writing which will apply to disclosures and uses made subsequent to the revocation dale.

Patient Name {Printed} m **u I I I**

Patient Signature {[u- Guargian} Daté

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PATIENT **RECORD** OF DISCLOSURES

in general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information [PHI]. The individual is also provided the right to request

confidential communications or that a communication of PHI he made by alternative means, such as sending bonespondence-to the individual‘s office insteadof the individual's home.

I wish to be contacted by the following manner (check all that apply):

Telephone: Home Work

to UK to leave message with detailed information in OK to leave message with detailed information
I] Familyr memberfs] with whom we can leave ' El Leave message with'oallback number only
messages: I: UK to fax to specified number:
Name:

Fax:

Relation to Patient:

Name:

_ Special instructions:

Relation to Patient:

El Leave message with callback number only

Patient Signature Please Print Name Date

Please note: Authorization is valid for 12 months from date of signature

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure of, and requests for PHI to the mmimum necessary to accomplish the intended purpose. These provisions do not apply to uses of disclosure made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Infomaation provided below,I if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPD may be permitted without prior consent in an emergency.