HIPPA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please read it carefully.
This notice of privacy practices describes how we may disclosure protected health information (PHI) to carry out treatment, payment, or health care operations and for the other purposes that are permitted or required by law. It also describes your right to access and control your protected health information. “Protected health information” is information about you, including demographics information, that may identify yuan that relates to your past, present and future physical and mental health or condition and related health care services.

Uses and Disclosure of Protected Health Information
Your protected health information may be used and disclosed by your physician, our staff and others outside our office that are involved in your care and treatment for the purpose of providing health care services to you; to pay your healthcare bills, to support the operation of the physicians practice and the other uses required by law.
Treatment: We will use and disclosure your protected health information to provide, coordinate or manage your health care and related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. Or your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose and treat you.
Payment: Your protected health information will be used as needed to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your protected health information be disclosed to your health plan to obtain approval for the hospital admission.
Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physicians practice. These activities include, but are not limited to two, quality assessment activities, employee review activities, training of medical students, licensing, and conducting and arranging for other business activities. For example, we may disclosure protected health information to medical students does see patients in our office. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary to contact you to remind you of an appointment.
We may disclose your Protected Health Information in the following situations without your authorization. These situations include, as required by law, Public Health Issues as requirement by law, Communicable Diseases, Health Oversight, Abuse or Neglect; Food and Drug administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors and Organ Donations, Research, Criminal Activity, Military and National Security, Workers Compensation, Inmates Required Uses and Disclosures. Under the law, we must make disclosures to you and when come up by the secretary of Health and Human services, to investigate or determine our compliance with the requirement of section 164. 500. Other permitted unrecorded 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, writing except to the extent that your physician or your physicians practice has taken in reliance on the use or disclosure indicated in the authorization.
Your Rights: The following statement of your rights with respect to your protected health information.
You have the rights to request a registration of your Protected Health Information: This means that you ask us not to use or disclose any part of your protected health information for the purpose of treatment payment or healthcare operations. You may also request that any part of your protected health information be disclosed to family members or friends that may be involved in your care or for notification purposes as described in this Notice of Privacy
Practices. Your request must state the specific restrictions, requested to whom you want the restrictions to apply. Your physician is not required to agree to a restriction that you may request if the physician believes it is in your best interest to permit use and disclosure of your protected health information, you are protected health information will not be restricted. You then have the right to use another healthcare professional.

You have the rights 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 have the right to have your physician amend your protected health information: if we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement, and we will provide you with a copy of any rebuttal.
you have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and we 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 the Secretary of Health and Human services if you believe your privacy rights have been violated by us you may file a complaint with us by notifying our privacy contact of your complaint.
We will not retaliate for filing a complaint.
We are required by law to maintain privacy of, and provide individuals with, this notice about our legal duties and privacy practice and respect to protect health information. If you have any objections with this form, please ask to speak with our capital HIPPA clients officer in person or by phone at our main office number.
Signature below is only acknowledgement that you have read and received this notice of our privacy practices:

Signature: ____

Print Name: ____

SIGNATURE ON FILE

- I authorized use of this form on **ALL** my insurance submissions.
- I authorize release of information to all my **Insurance Companies.**
- I understand that **I AM RESPONSIBLE** for **MY Bill**.
- I authorize my doctor to act as **MY** agent in helping me obtain payment from my Insurance Companies.
- I authorize payment directly to my doctor.
- I permit copy of this authorization to be used in place of the original.

PRINT NAME: ______________________________ SIGNATURE: ______________________________

DATE: ____________