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HIPAA POLICY 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. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. This Notice of Privacy Practices describes how we will be handling confidential Protected Health Information in accordance with the HIPAA regulations. Please review it carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually protected health information ("Protected Health Information", defined herein) used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential.

"Protected Health Information" is information that (1) identifies (or could be reasonably used to identify) an individual, (2) is created or received by a HIPAA covered entity (a health care provider, health plan or health care clearinghouse) and (3) relates to the past, present or future physical or mental health of the individual, the provision of health care to the individual, or the past, present or future payment for the provision of health care to the individual. Protected Health Information includes medical conditions, health status, claims experience, medical histories, physical examinations, genetic information and evidence of disability.

This Act gives you, the patient, significant new rights to understand and control how your Protected Health Information is used. We are required by law to maintain the privacy of your Protected Health Information and to provide you with notice of our legal duties and privacy practices with respect to Protected Health Information. HIPAA provides penalties for covered entities that misuse personal health information.

You will be provided with the written acknowledgement form which the patient will be asked to sign. The acknowledgment form merely signifies that the patient has received a copy of the Notice.

Treatment means providing, coordinating, or managing health care and related services, by one or more health care providers. An example of this would include a physical examination.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

“Authorizations” are basically patient consent forms that contain certain specific provisions required by HIPAA. Typical situations where authorizations are needed include, but are not limited to the release of medical records for purposes of further medical treatment and the release of medical records for purposes of school or employment. The authorization will identify (a) the specific individuals authorized to make the requested use or disclosure of the Protected Health Information, (b) the specific individuals to whom the practice may make the requested use or disclosure of the Protected Health Information, (c) a description of each purpose of the requested use or disclosure, (d) the expiration date of the use or disclosure and (e) a statement of the patient’s right to revoke the Authorization at any time in writing along with the procedure for revocation. The authorization form will include an “expiration date” or “expiration event” upon which the authorization is no longer effective. This may be any date or event desired by the patient relating to him or her or the purpose of the disclosure.

Minors and incompetent patients generally cannot sign the written acknowledgment form for themselves. Typically, they do not have the legal authority to do this. Only the person(s) who has the ability to give informed consent for the minor or incompetent patient, under state law, can exercise these rights.

You have the following rights with respect to your Protected Health Information, which you can exercise by presenting a written request to us:

> The right to request restrictions on certain uses and disclosures of Protected Health Information, including those related to disclosure to family members, other relative, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
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> The right to reasonable requests to receive confidential communications of Protected Health Information from us by alternative means or at alternative locations.
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> The right to inspect and copy your Protected Health Information.
> The right to amend your Protected Health Information.
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> The right to obtain a paper copy of this notice from us upon request.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our notice of Privacy Practices and to make the new notice provisions effective for all Protected Health Information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office. We will keep on hand paper copies of the

Notice should you request a take-home copy. If the Notice is ever materially changed in terms of the description of permitted disclosures, patient rights, our legal duties, or other privacy practices, then the Notice will be redistributed to you.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaints with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the polices and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact the following for more information:

The U.S. Department of Health & Human Services Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775