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Phone 210.481.4120
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HIPAA NOTICE OF PRIVACY PRACTICES
FOR PROTECTED HEALTH INFORMATION

This Health Information Privacy Notice describes how we protect your Protected Health Information (PHI). Protected Health Information includes identifiable information which relates to your treatment and/or payment for health care services. This notice also describes your rights with respects to the Protected Health Information and how you can exercise those rights.

We are required to provide this Notice to you by the Health Insurance Portability and Accountability Act ("HIPAA"). We are required by law to :

- Maintain the privacy of your Protected Health Information;
- Provide you this notice of our legal duties and privacy practices with respect to your Protected Health Information; and
- Follow the terms of this notice.

We protect your Protected Health Information from inappropriate use or disclosure. Our employees are required to comply with our requirements that protect the confidentiality of Protected Health Information. They may look at your Protected Health Information ONLY when there is an appropriate reason to do so. The main reasons for which we may use and disclose your Protected Health Information are:

- **For payment:** We may use and disclose Protected Health Information to pay for processing your payment.
- **For Health Care Operations:** We may also use and disclose Protected Health Information at your request for your insurance needs.
- **To Avert a Serious Threat to Health or Safety:** We may disclose Protected Health Information to avert a serious threat to someone's health or safety.
- **We may use Protected Health Information to provide information about services that may be of interest to you.**
- **For Law Enforcement or Specific Government Functions:** We may disclose Protected Health Information in response to a request by law enforcement officials made through a court order, subpoena, warrant, summons, or similar process. We may disclose Protected Health Information about you to federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

- **When Requested as a Part of a Regulatory or Legal Proceeding:** If you or your estate are involved in a lawsuit, divorce or a dispute, we will release your Protected Health Information at your request.
- **Other use of Protected Health Information:** Other uses and disclosure of Protected Health Information not covered by this notice and permitted by the laws that apply to us will be made only with your written authorization or that of your legal representative. If we are authorized to use or disclose Protected Health Information about you, you or your legally authorized representative may revoke that authorization, in writing at any time, except to the extent that we have taken action relying on the authorization. You should understand that we will not be able to take back any disclosure we have already made with authorization.
- **Cost of Processing PHI Request:** Due to the cost of preparing and transmitting requested PHI, we will charge a $30 flat fee for up to 25 pages and an additional $1.00 per page thereafter.

In most cases, you have the right to inspect and obtain a copy of the Protected Health Information that we maintain about you.

- **Right to Amend Your Protected Health Information:** If you believe that your Protected Health Information is incorrect or that an important part of it is missing, you have the right to ask us to amend your Protected Health Information while it is kept by or for us. We many deny your request if you ask us to amend Protected Health Information that:
    - Is accurate and complete;
    - Was not created by us, unless the person or entity that created the Protected Health Information is no longer available to make the amendment;
    - Is not part of the Protected Health Information kept by or for us, or
    - Is not part of the Protected Health Information which you would be permitted to inspect and copy.
- **Right to a list of Disclosures:** You have the right to request a list of the disclosures we have made of Protected Health Information about you. This list will NOT include disclosures made for treatment, payment, health care operations, for purpose of national security, made to law enforcement or to corrections personnel, or made pursuant to your authorization or made directly to you. You must state the time period from which you want to receive a list of disclosures. The time period may not be longer than six years and may not include dates before February 1, 2017. We will provide one accounting a year for free but will charge a reasonable cost-cased fee if you ask for another one within 12 months.
- **Right to Request Restrictions:** You have the right to request a restriction or limitation on Protected Health Information we use or disclose about you for treatment, payment or health care operations, or that we disclose to someone who may be involved in payment for your care, like a family member or friend. While we will consider your request, we are not required to agree with it.
- **Right to Request Confidential Communication:** You have the right to request that we communicate with you about Protected Health Information in a certain way or at a certain location if you tell us that communication in another manner may endanger you. For example, you can ask that we only contact you at work or by mail.
- **Right to File a Complaint:** If you believe your privacy rights have been violated, you may file a complaint with us. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
- **Change to This Notice:** We reserve the right to change notice effective for Protected Health Information we already have about you as well as any Personal Health Information we receive in the future.

Additional Information:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html



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PATIENT ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

_____

Print Patient's Name Date

I, _____, acknowledge that I
(Patient or Parent or Legal Guardian) have either received a copy of this office's **NOTICE OF PRIVACY PRACTICES** or that this office's **NOTICE OF PRIVACY PRACTICES** was made available to me to receive.

I, _____, consent to the use and disclosure
(Patient or Parent or Legal Guardian) of my Protected Health Information by your office for Treatment, Billing / Payment and Health care operations as outlined in the **NOTICE OF PRIVACY PRACTICES**.

_____ _____

Patient or Parent or Legal Guardian Signature Date

_____

Printed Name

_____ _____

Signature of Office Representative Date