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HIPPA Notice of Privacy Practices

The Health Insurance Portability and Accountability Act (HIPPA) provides safeguards to protect your privacy. HIPPA provides certain rights and protections to you as the patient on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. I balance these rights with my goal of providing you with quality professional service and care. As such, I have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information that is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination rooms, etc. Those records will not be available to persons other than the office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI, and other documents or information.

2. It is policy of this practice to remind patients of their appointments. I may do this by telephone, e-mail (both encrypted and unencrypted), U.S. Mail, or by any means convenient for the practice and/or requested by you. I may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPPA.

4. You understand and agree to inspections of the office and review of documents, which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints to the attention of the office manager or physician.

6. Your confidential information will not be used for marketing or advertising of products, goods, or services.

7. I agree to provide patients with access to their records in accordance with the state and federal laws.

8. I may modify any of these provisions to better serve the needs of the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request changes in certain policies used within the office concerning your PHI. However, I am not obligated to alter internal policies to conform to your request.

[ ] **I hereby authorize** Dena Freedman-Muchnick and affiliates, employees, or agents to release any personal health information (e.g., information relating to the diagnosis, records, treatment, claims payments, and healthcare services) provider or to be provided me to:

[ ] Parent / Spouse / Relative _____

[ ] Referring Provider _____

[ ] Primary Care Doctor _____

[ ] Other Consultants _____

[ ] **I do not authorize** Dena Freedman-Muchnick or affiliates to release any medical information.

This **Release of Information will remain in effect until terminated by me in writing.*

I, _____, do hereby consent and acknowledge my agreement to the terms set forth in the HIPPA INFORMATION FORM and any subsequent changes in office policy.

Signed: _____Date: _____ Witness: _____Date: _____
Patient Name (if minor): _____

Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov