# NOTICE OF PRIVACY PRACTICES

## USE AND DISCLOSURE OF HEALTH INFORMATION

I may use your health information (information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)) for the purposes of providing you treatment, obtaining payment for your care and conducting health care operations.

Treatment – Your health information will be recorded and used to determine the course of treatment that is best for you. The sharing of your health information may include other health care providers involved in your care within the confines of my practice.

Payment – Your health care information will be used in order to assist you to be able to receive reimbursement payments for services. A bill may be sent to either you, a third-party payer or a billing service company with accompanying documentation that identifies you, your insurance information, your address, your date of birth, your diagnosis, procedures performed, supplies used and any industry standard information necessary to submit a health insurance claim form.

Health Care Operations – Your health care information will be used as necessary in order to improve the quality and effectiveness of the care and services I provide. For example, with your written consent, I may discuss your case with another health care provider to increase my understanding of your unique situation. In the event of a medical emergency which, for the sake of your welfare, requires information from me about your state of health that is critical to your proper care in a medical setting other than my office, I will communicate with the necessary medical personnel any information that I deem to be appropriate. In signing this disclosure you are giving consent for me to take such an action.

Appointment reminders – I may contact you with appointment reminders.

Treatment alternatives – I may contact you with information about treatment alternatives and other health-related activities that may be of interest to you.

Patient Education – I may contact you to inform you of new services that I offer or events that I am hosting or attending.

Communications with Family – In an urgent situation, one or more people, a family member, or close personal friend, identified by you, may be given information relevant to your care. I may contact this person in such a situation.

Your Emergency Contact: _____

Telephone_____

Research/Education – Your information may be disclosed to researchers or educators upon the assurance that protocols have been established to ensure the privacy of your health information.

Law Enforcement – Your health information will be disclosed when it is required under federal, state, or local law.

Other than stated above when applicable, I agree not to use or disclose your health information without your written authorization. Other than activity that has already occurred, you may revoke this authorization in writing at any time.

## YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

Your health record is the physical property of the health care practitioner or facility that compiled it, but the content is about you and therefore belongs to you. You have the right to request restrictions on certain uses and disclosures of your information, and to request amendments be made to your health record. Your rights include being able to review or obtain a paper copy of your health information (a copy fee may be requested) and to receive an accounting of the disclosures that have been made of your health information (after the effective date of this Notice) for most purposes other than treatment, payment or health care operations. Other disclosures excluded are direct disclosures to yourself, family or friends involved in your care. You may also request communications of your health information be made by reasonable alternative means or to reasonable alternative locations. You will need to provide details about how to contact you including a valid alternative address. If we are unable to contact you using the information you provide, we may contact you using any information on file. We will not require you to explain why you want this communication. We will honor reasonable requests.

If we are unable to contact you using the requested ways or locations, we may contact you using any information on file, including an email address given to us by you. You also may want to communicate with us via e-mail. Because e-mail may contain your personal health information and e-mail is not a secure communication, we ask for your specific authorization to communicate with you using this method by signing this form and initialing here _____.

All requests must be submitted to me in writing (Jennifer Wood, 8 Nonantum Lane, Chatham MA 02633). You have the right to a paper copy of this Notice and may request one at any time by contacting me at 774.994.0206. You have the right to file a complaint with me or the Secretary of Health and Human Services, with no fear of retaliation.

## MY RESPONSIBILITIES

I am required by law to maintain the privacy of your health information and to provide you this Notice of duties and privacy practices. I am required to abide by the terms of this Notice and to notify you if I am unable to grant your requested restrictions or desires. I reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that I maintain. If I change this Notice, you will be informed at your next office visit after such a change has been made.

_____ _____

Patient Signature Date