NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE SHARED AND/OR DISCLOSED. REVIEW IT CAREFULLY.

Your medical information may be used and/or disclosed by your medical provider or agents of this office in efforts to provide medical services, bill and receive payment for those services, and other uses as required by law.

Your information will be used and/or disclosed to manage your medical care and services necessary to provide care to you. Your information may be shared with a third party for the purpose of management and coordination of care.

Your medical information will be provided, as necessary, to bill for services rendered to you.

Your information may be used to support business activities and requirements such as quality assurance monitoring, licensing or relicensing, conducting routine business operations, training of staff and students, and audits. This list is not all inclusive of how your information may be used.

We may share your information without your approval as required by law. Such situations may include but are not limited to when required by law for public health issues, mandatory reporting of certain communicable diseases, reasonable suspicion of abuse or neglect, when legally required as part of legal proceedings, when legally required by law enforcement, with funeral home services, organ donation services, criminal activity, when deemed a matter of national security, workers' compensation claims, and/or if in the custody of a law enforcement organization at the time care is rendered.

You have the right to request a copy of your medical record. This request must be formally submitted in writing. Your request will be fulfilled in a reasonable amount of time, usually 30 days. This office may deny your request in cases where that information is protected by law and unable to be released. Information collected as part of a criminal proceeding may not be available for review.

You have the right to correct inaccurate information.

You have the right to request restriction of how your information is shared. This office is not bound by this request and therefore it may be denied.

You have the right to delegate someone to act on your behalf in the event you are not able to make decisions for yourself. It is your responsibility to inform this office if you have enacted an advanced care plan, healthcare power of attorney, or living will. Copies of these documents should be supplied to this office and will be added to your medical record.

You have the right to request how you receive confidential communications.

You have the right to request who your information has been shared with and/or what information has been disclosed.

You have the right to receive a copy of this notice. A request for a copy can be made in the office or by submitting a written request.

We reserve the right to update this notice. If updated, you have the right to receive a copy of the updated notice either in the office or via a written request.

If you have a complaint or feel your rights have been violated, you may make this complaint known to a member of the office staff. You may also submit a complaint in writing to:

U.S. Department of Health and Human Services
Office for Civil Rights, 200 Independence Ave S.W., Washington D.C. 20201

Or by calling 800-368-1019 or by visiting https://www.hhs.gov/hipaa/filing-a-complaint/what-to-expect/index.html.

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge that you have been given the opportunity to review the notice of privacy practices for County Med, LLC. You acknowledge that you have been given the option to receive a copy of this notice at signing.

Our "Notice of Privacy Practices" is subject to change. If we change this notice, you may obtain a copy in the office or by written request.

Patient Name (Printed): _____

Patient/Parent/Guardian Signature: _____

Relationship (if signed by someone other than the patient): _____

Date: _____