Jennifer Lorine, DO
Office Address: 725 Skippack Pike Blue Bell PA 19422
Mailing Address: PO Box 83 Gwynedd PA 19436
610-613-5042

NOTICE OF PRIVACY PRACTICES (HIPAA)

This notice describes how your health information may be used or disclosed and how you can access this information.

My commitment regarding your health information: I understand that health information is personal and I am committed to protecting it. I create a record for each patient documenting the care and services that I provide. I need this record to comply with legal requirements and to provide you with quality care. This notice will tell you how I may use and disclose health information in addition to describing your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

- Make sure that protected health information ("PHI") that identifies you is kept private.
- Give you this notice of my legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.
- I can change the terms of this Notice, and such changes will apply to all information I have about you. The notice will be available upon request

How I may use and disclose health information: The following categories describe ways that I could use and disclose health information

*For Treatment, Payment, or Health Care Operations: Federal privacy regulations allow health care providers who have direct treatment relationship with the patient to use or disclose the patient's personal health information without the patient's written authorization, to carry out the health care provider's own treatment, payment or health care operations.

*Disclosures for treatment purposes are not limited to the minimum necessary standard. Your case may be discussed with your PCP, referring specialist or your other healthcare providers & a letter may be sent to them.

*Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I prefer to discuss this with patients prior if possible.

Uses and disclosures that may require your authorization: Notes: Disclosure of notes from office visits requires your Authorization unless the use or disclosure is:

*For my use in treating you
* For my use in training or supervising medical students or residents
* For my use in defending myself in legal proceedings instituted by you.
* For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA
*Required by law
* Required by a coroner who is performing duties authorized by law.
* Required to help avert a serious threat to the health and safety of others.

<u>As a physician, I will not sell your PHI or use it for marketing purposes.</u>

Some Uses or Disclosures do not require your authorization: Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

*When disclosure is required by law.
*For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety. (Physicians are mandated reporters of child abuse)

*For health oversight activities, including audits and investigations.
*For judicial and administrative proceedings, including responding to a court or administrative order
*For law enforcement purposes or specialized government functions
*To coroners or medical examiners
*For research purposes (I am not currently involved in clinical research)

*For workers' compensation purposes in order to comply with workers' compensation laws.

* Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

Some uses and disclosures require that you to have the opportunity to object :

Disclosures: I may provide your PHI to a person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

Your rights with respect to your PHI

*The Right to Request Limits on Uses and Disclosures of Your PHI.
*The right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full. As I am opted out of insurance and Medicare, I do not contact health plans on your behalf, unless they have requested information and we discuss what information would be given to the health plan.
*The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way. However, I prefer that no PHI be sent by email
*The Right to See and Get Copies of Your PHI. You have the right to get a paper copy of your medical record. I may charge a reasonable fee for doing so, based on what is allowable by the state of Pennsylvania.
*The Right to Get a List of the Disclosures I Have Made regarding your PHI
*The Right to Correct or Update, or add missing information to your PHI.
*The Right to Get a Copy of this Notice.

EFFECTIVE DATE OF THIS NOTICE September 3, 2020

Acknowledgement of Receipt of Privacy Notice: Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By signing below, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

_____

Name

_____

Signature

_____

Date

For more information see: https://www.hhs.gov/hipaa/for-individuals/notice-privacy-practices/index.html