OFFICE HIPAA NOTICE OF PRIVACY PRACTICES

AUTHORIZATION FOR THE USE OF AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. **If you have any questions about this Notice please contact our Privacy Officer** (the Office Manager), **Fay-West Medical, 127 Simpson Road, Brownsville, PA, 15417. Or call 724-785-7080.**

This Notice of Privacy Practices describes how Fay-West Medical may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information.

"Protected health information" is information about you, that may identify you and that relates to your past, present or future physical, medical and/or mental health or condition and related health care services. We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time, but will provide a new notice to you upon treatment following the change.

Your Health Information Rights.

Although your health record is the physical property of the Fay-West Medical, the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information
- inspect and obtain a copy of your health record unless access is restricted by law
- request an amendment of your health record
- to obtain/receive an accounting of disclosures of health information
- request communications of your health information by alternative means or at alternative locations
  obtain a paper copy of the notice of information practices upon request .

Any request to amend or copy your protected health information must be made in writing. Requests for restrictions must be made in writing and will not be accepted if it has a negative impact on the operational delivery of care.

Our Responsibilities

This practice is required to:

- maintain the privacy of your health information
- provide you with a notice as to our legal duties and privacy practices with respect to your protected health information
- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

If you believe your privacy rights have been violated, you can file a complaint with our Privacy Officer or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint. You may contact our Privacy Officer, at 724-785-7080 for further information about the complaint process or to obtain additional information about any other matters in this notice.

Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment. When you receive treatment, the provider will record information in your file and it will be used to determine the course of treatment that will work best for your condition. Copies of your record will be provided to the healthcare provider which will include copies of tests and reports in order to permit quality care. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We will use your health information for payment. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used. We will use your health information for regular health operations. Members of our quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.
Business associates: There are some services provided in our organization through contracts with business associates. These may include laboratories, our billing service, collection agencies, accreditation bodies, consultants, lawyers, and auditors. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Notifications: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, general condition or your death. Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care, or payment related to your care. If your are incapacitated or were not present to agree or object to the disclosure of your health information, we can make the determination whether the disclosure is in your best interest.

Disasters: In the case of a disaster, we may disclose health information to a public or private entity authorized by law to assist in disaster relief efforts.

Law: We may disclose health information as required by law or in response to a valid subpoena or by law officials during an investigation.

All other uses and disclosures will be made only with your authorization and such authorization may be revoked by you at any time by giving us written notice.

Acknowledged and Agreed to by:

or, on behalf of the patient:

Patient: ______________________________ ______________________________

Signature Signature

______________________________ ______________________________

Printed Name Printed Name

______________________________ ______________________________

Address Address

______________________________ ______________________________

City State Zip City State Zip

Date: ______________________________ Date: ______________________________

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ASSIGNMENT OF BENEFITS - FINANCIAL RESPONSIBILITY

Patient Signature______________________________**Date**______________

I request that payment of Insurance benefits due me, be made directly to the Practice for any and all services performed or other items furnished to me such as medical supplies, durable medical equipment, or other services or products furnished to me by that Practice. I also authorize any holders of my insurance coverage, medical information concerning my treatment, medical device needs, or my diagnosis or prognosis to release that information to my Practice, Medicare, Insurance Carrier or the Health Care Financing Administration, as regulated by the Notice of Privacy Practices (HIPAA Regulations), sections 1171 through 1179 of the Social Security Act, and section 262 of Public Law 104-191, and section 264 of Public Law 104-191. I recognize that if my Practice submits claims, and if those claims are determined to be not reimbursable, I am financially responsible to that Practice for those services, medical supplies, or other durable medical equipment provided.

Patient ______________________________ Witness______________________________

Signature Signature

______________________________ ______________________________

Address Address

______________________________ ______________________________

City State Zip City State Zip

Practice: **Fay-West Medical, 127 Simpson Road**
Brownsville, PA, 15417
724-785-7080

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