

HIPAA / NOTICE OF PRIVACY PRACTICES – Page 1

In accordance with HIPAA laws, this notice describes how your health information may be used or disclosed and how you, the patient, can access this information. Please review the following carefully.

The law permits us to use or disclose your health information to the following:

Another specialist or physician who is involved in your care.

Your insurance company, for the purpose of obtaining payment for our services.

Our staff, for the purpose of entering your information into our computerized system

Other entities during the course of your treatment, in order to obtain authorizations, referral visits, scheduling of tests, etc. Much of this information is sent via fax which is a permitted use allowed by law. We have on file with these sources verification for the confidentiality of the fax used and its limited access by authorized personnel.

If this practice is sold, your health information will become the property of the new owner.

We may release some or all of your health information when required by law. Except as described above, this practice will not use or disclose your health information without your prior written authorization.

Federal and State law allows us to use and disclose our patients' protected health information in order to provide health care services to them, to bill and collect payments for those services, and in connection with our health care operations.

We also use a shared Electronic Medical Record with the BASS and John Muir Health physicians that allows both our physicians and staff access to our patients' health information. The purpose for this access is to expedite the referral of patients and to assist in providing and managing care in a coordinated way. Information in the Electronic Medical Record can be released outside the system only with the patient's express authorization or as otherwise specifically permitted or required by law.

The law also establishes patient rights and our responsibility to inform you of those rights. These include:

You have the right to request in writing any uses or disclosures we make with your health information beyond the normal uses referenced above.

You have the right to limit the use or restrict the use disclosure of your health information. Our office will follow any restrictions notated by you on the reverse side of this form.

You have the right to request in writing to inspect and/or receive a copy of your health information.* Our office may charge a reasonable fee to cover copying and mailing of these records to you.

You have the right to request an alternate means or location to receive communications regarding your health information.*

You have the right to request in writing an amendment or change to your health information. Our office may agree or disagree with your written request, but we will be happy to include your statement as part of your records. If an agreement to amend or change is acceptable, please be advised that previous documentation is considered a legal document and cannot be deleted or removed. Our office will simply notate the amendment and the reason for it and add it to your records.

* Conditions and limitations may apply; obtain additional information from our Privacy Officer.

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We may use your information to contact you. For example, we may mail you an appointment reminder card or call you with information regarding your care. If you are not at home, this information may be left on your answering machine or with the person who answered the phone. In an emergency, we may disclose your health information to a family member or another person designated responsible for your care. **Please designate who our offices CAN disclose your health information to by checking the boxes below:**

OK to Spouse: _____

OK to ALL family members: (please list names of family members, below)

OK to Other: _____

OK to leave health information on answering machine or voice mail

DO NOT RELEASE ANY INFORMATION to anyone other than myself (the patient).

DO NOT RELEASE TO _____

We reserve the right to change our privacy practices and the conditions of this notice at any time and without prior notice. In the event of changes, an updated notice will be posted and our office will notify you of the changes in writing. You have the right to file a complaint with the Department of Health and Human Services, 200 Independent Avenue, S.W., Room 509F, Washington, DC 20201. Our office will not retaliate against you for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact Amie Michaels at 925-979-5327.

This notice goes into effect as of December 5, 2017.

ACKNOWLEDGEMENT

This acknowledges that you have received and read a copy of our Privacy Practices Notice. This document is not a contract, authorization, release, or consent form. This document will remain as part of your records.

Signed: _____ Date: _____

Patient's Name: _____ Date of Birth: _____

If person signing is not patient please provide:

Name: _____

Relationship to patient: _____