

Today's Date: _____

NOTICE OF PRIVACY PRACTICES

To our patients:

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our Commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclose of your health information under special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to court or administrative order.
3. If required to do so by law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. Or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official
8. For Workers Compensation and similar programs

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment of your care such as family members and friends. We are not required to agree to your request, however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Medical Records.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be in writing and submitted to Jennifer, Office Manager.
5. Right to copy of this notice. You are entitled to receive a copy of this NOTICE OF PRIVACY PRACTICES. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, please contact Jennifer, Office Manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact Jennifer, Office Manager.

I hereby acknowledge that I have read and understand the Advanced Orthopaedics and Sports Medicine, P.C. **Notice of Privacy Practices.**

Print Patient Name: _____

Signature: _____

Today's Date: _____

I authorize AOSM to discuss above named patient's health/medical and or billing information with the following person(s):

(If left blank, we are unable to discuss your information with anyone.)

Name: _____ Relationship to patient: _____

1. _____

2. _____

3. _____