HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us, whether electronically, on paper, or orally, are kept confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we maintain the privacy of your health information and how we may use and disclose this information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations. 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.

Any other uses and disclosures will be made only with your authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

The following are your rights to your protected health information:
- The right to request restrictions on certain disclosures of protected health information, including those related to disclosures to family members, relatives, personal friends, or any other person identified by you. We are not required to agree to a requested restriction.
- The right to reasonable requests to receive confidential communications of protected health information.
- The right to inspect and copy your personal health information.

We are required by law to maintain the privacy of your health information and to provide you with notice of legal duties and privacy practices.

I understand that if I would like to review the full HIPAA Policy for Rindfleisch Family Practice, PLLC, a copy can be provided to me upon my request. I have read and reviewed the summarized policy above, and I agree to the terms listed.

Patient/Responsible Party Signature _____

Print Name _____ Date _____