Patient Rights

Restrictions

You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preferences from our patients.

Confidential Communications

You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor reasonable requests for confidential communications.

Inspect and Copy Your Health Information

You have the right to read, review and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information please let us know. We may need to charge you a reasonable fee to duplicate and assemble you copy.

Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.

Documentation of Health Information

You have the right to ask us for a description of how and where your health information was used by our office for any reason other that for treatment, payment or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than four years at a time. We may need to charge you a reasonable fee for your request.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail a copy to you.

We are required by law to maintain the privacy of your health information and to provide you and your representative this Notice of Privacy Practices. We are required to practice the policies described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all our patients will receive a copy of the revised Notice.

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information.
Please let us know your concerns or complaints in writing.

Notice of Privacy Practices

Dear Patient,

The Federal government has sought to standardize and protect the privacy of the exchange of your health information through the Health Insurance Portability and Accountability Act of 1996 (or HIPPA). The privacy regulations generated from this law apply to all within the health care industry that handles information electronically.

Although we do not transmit any personal health information electronically, we are taking this new law seriously. We have been working diligently to become compliant and HIPPA requires us to notify our patients of our privacy practices. Please review the enclosed notice carefully. This notice describes how your health information may be used and disclosed and how you can get access to this information. The Notice of Privacy Practices is effective April 1, 2003.

Sincerely,

Barbara Fitzgerald
Privacy Officer

Patient Acknowledgement

Thank you for taking time to review our policies and procedures regarding the confidentiality of your health information. If you have any questions for us, we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by signing below.

_____ _____

Patient/parent or guardian's signature Date