

NOTICE REGARDING PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCUSSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

The privacy of medical information is important to us and we are committed ethically and by law to protecting your privacy and personal information. This notice is intended to let you know how your information may be used and shared. It also details your rights and duties regarding the use of this information. "Information" refers to the entire content of your medical record generated under the care of North Cypress Internal Medicine & Wellness.

1. Your medical information may be disclosed for purposes of treatment or services. An example would be disclosure to other health care professionals involved in your care.
2. Your medical information may be disclosed for payment purposes. An example would be providing information to your insurance company regarding services rendered in order to receive payment.
3. Your medical information may be disclosed for our health care operations.
4. Your medical information may also be disclosed as required under law for activities such as but not limited to judicial proceedings, public health activities, public health authorities if reason exists to suspect a serious threat to your health or safety or that of others, and health oversight activities.

You have a right to:

1. Look at or get copies of your medical information. You must make this request in writing on the appropriate form provided by *our* office. A fee may be charged for copying and postage.
2. Receive a list of our business associates who have received your medical information for purposes *other than* treatment, payment or operations.
3. Request additional restrictions on use or disclosure of your medical information. However, we are not required to agree to your request. But if we do, we will abide by our agreement except in the case of an emergency. Requests must be in writing.
4. Request that we communicate with you about your medical information by different means or to different locations. Your request must be in writing and within the current available means of communications available at the office.
5. Request that we change your medical information. We may deny your request and if denied will provide you a written explanation as to the reason for denial. You may respond with a statement of disagreement which will be added to your medical record. If your request for change is accepted, we will make a reasonable effort to tell others of the change if you request and to include the change in future sharing of that information.
6. You may request a paper copy of this privacy notice. Requests should be made in writing.

I _____ have read and understand and agree to this notice/ policy. _____
NAME DATE

If you have questions about this notice, please ask the receptionist for help or speak with your physician directly. If you feel we have violated your privacy rights, contact your physician. You may also submit a written complaint to the U.S. Department of Health and Human Services.

- These privacy practices are currently in effect and will remain so until further notice. We have the right to change our privacy practices and will change this notice and make the new notice available upon request. (March 2003)