



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 REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly 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.

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

- **Treatment** means providing, coordination, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders of 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 written 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.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment for third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

A complete description of *Notice of Privacy Practices* can be located at http://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/npp_fullpg_healthplan.pdf. Please inform our office if you would like a printed copy.

Health Insurance Portability and Accountability Act (HIPAA)

Acknowledgement of Receipt of Privacy Notice

I, patient (or representative for patient) of the Allergy and Asthma Specialists of Frederick (AASF), **have been provided a copy of the Notice of Privacy Practices**, which describes my privacy rights in accordance with federal and state requirements. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE

DATE

Communication Consent

I understand that I may be contacted by AASF on my cellular or home phone, by text or email using any contact information provided on the demographics form, unless otherwise specified. The doctor or staff may leave a message regarding my health information or my account. In addition, **I authorize AASF to share medical/billing information about my care/account with the following individuals as indicated below:**

Names	Relationship (s)	Phone #(s)
_____	_____	_____
_____	_____	_____
_____	_____	_____

It is my responsibility to notify AASF of any changes to this form.

PATIENT NAME

PHONE NUMBER (mark one): HOME____ CELL____

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE

DATE