HIPAA NOTICE OF PRIVACY PRACTICES

Effective October 1, 2014

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

This notice is provided to you pursuant to the Health Insurance Portability and Accessibility Act of 1996 and its implementation regulations ("HIPAA"). It is designed to tell you how we may, under federal law, use or disclose your Health Information. It has been updated to the HITECH Omnibus Rule requirements.

I. Your Rights.
You have the right to request restrictions on the uses and disclosures of your Health Information. However, we are not required to comply with all requests. You are allowed to restrict transmittal of health care charges to your insurance carrier if you pay for those services, in full, by other means.

You have the right to receive your Health Information through confidential means and in a manner that is reasonably convenient for you and us.

You have the right to inspect and copy your Health Information. You may request your records in digital format and have your records sent digitally to another provider with written authorization if we have the capability to do so.

You have a right to request that we amend your Health Information that is incorrect or incomplete. We are not required to change your Health Information and will provide you with information about our denial and how you can disagree with the denial.

You have a right to receive a accounting of disclosures of your Health Information made by us, except that we do not have to account for disclosures: authorized by you; made for treatment, payment, health care operations; provided to you; provided in response to an Authorization; made in order to notify and communicate with approved family members; and/or for certain government functions, to name a few.

You have been provided with a paper copy of this Notice of Privacy Practices. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, please contact our HIPAA Compliance Officer at (847) 867-5202.

II. We may use or disclose your health information for purposes of treatment, payment or healthcare operations without obtaining your prior authorization and here is one example of each:

We may provide your health Information to other health care professionals, including doctors, nurses and technicians, for purposes of providing you with care.

Our billing department may access your information and send relevant parts to insurance companies to allow us to be paid for the services we render to you.

III. We may also use or disclose your health information under certain circumstances without your prior authorization.
However, in general, we will attempt to ensure that you have been made aware of the use or disclosure of your health information prior to providing it to another person. Some instances where we may need to disclose information include but are not limited to:

To notify and/or communicate with your family. We will only communicate with family members that we are authorized to communicate with based on your completion of the Authorization to Disclose Health Information form.

As required by law.

For Health Oversight Activities. We may use or disclose your health information to health oversight agencies during the course of audits, investigations, certification and other proceedings.

In response to Civil Subpoenas or for Judicial Administrative Proceeding. We may use or disclose your health information, as directed, in the course of any civil administrative or judicial proceeding.

To Law enforcement Personnel. We may use or disclose your health information to a law enforcement official to comply with a court order or grand jury subpoena and other law enforcement purposes.

For purposes of organ donation. We may use or disclose your health information for purposes of communicating to organizations involved in procuring, banking or transplanting organs and tissues.

For Worker's Compensation. We may use of disclose your health Information as necessary to comply with worker's compensation laws.

IV. For all other circumstances, we may only use or disclose your health information after you have signed an authorization. If you authorize us to use or disclose your health information for another purpose, you may revoke your authorization in writing any time.

Use or disclosure of Psychotherapy notes. *Written* authorization is required if our practice intends to use of disclose psychotherapy notes.

Breach Notice. All patients will be informed if there is a breach, as defined by federal rules, of their unsecured protected health information as required by the HIPPA regulations.

Right to request restrictions for disclosures related to self-payment. Our practice is required to comply with a request not to disclose health information to a health plan for treatment when the individual has paid in full out-of-pocket for a health care item or service and signed our "Do Not File Insurance Form".

V. You should be advised that we may also use or disclose your health information for the following purposes:

Appointment Reminders. We may use your health information in order to contact you to provide appointment reminders or to give information about other treatments or health-related benefits and services that may be of interest to you.

Change of ownership. In the event that our business is sold or merged with another organization, your health information/record will become the property of the new owner.

VI. Our Duties:

We are required by law to maintain the privacy of your health information and to provide you with a copy of this notice.

We are also required to abide by the terms of this notice.

We reserve the right to amend this notice at any time in the future and to make the new notice provisions applicable to all your health information, even if it was created prior to the change in the notice. If any such amendment is made that materially changes this notice, we will provide you with another copy.

VII. Complaints to our Practice and the Government.

You may make complaints to our HIPAA Privacy Officer or the Security of the Department of Health and Human Services ("DHHS") if you believe your rights have been violated.

We will review all complaints in a professional manner and keep you informed of your rights as our patient.

We promise not to retaliate against you for any compliant you make about our privacy practices.

VIII. Contact Information.

You may contact us about our privacy practices or file a complaint by call our Privacy Officer at (847)867-5202.

You may contact the DHHS at: The U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201, Telephone: 202-619-0257, Toll Free: 1-877-696-6775.

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____