PREVENTIVE CARDIOLOGY CONSULTANTS, P.A.
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 righ 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 are required to maintain the privacy of your health information and how we may use and disclose your health information.

If you sign a Consent Form, we may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would be referrals to a surgical pediatric provider.

- 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 servic 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, without prior consent, use or disclose protected health information to carry out treatment, payment, or healt care operations in the following circumstances:

- In emergency treatment situations, if we attempt to obtain such consent as soon as reasonably practicable after the delivery of such treatment;

- If we are required by law to treat you, and we attempt to obtain such consent but are unable to obtain such consent; or

- If we attempt to obtain your consent but are unable to do so due to substantial barriers to communicating wit you, and we determine that, in our professional judgment, your consent to receive treatment is clearly inferre from the circumstances.

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

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

- 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 an

other person identified by you. We are, however, not required to agree to a requested restriction. If v do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health informati from us by alternative means or at alternative locations.
- 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.

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

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to mak new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:
Corinne Abdou, Privacy Officer
7801 Eash Bush Lake Rd, Suite 320
Bloomington, MN 55439 (952) 831-5773

For more information about HIPAA or to file a complaint:
U.S. Dept. of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

☐ **Treatment Authorization** – *I hereby authorize PREVENTIVE CARDIOLOGY CONSULTANTS, P.A., or their designee(s), to treat my or the patient's condition as they deem appropriate.*

☐ **Record Release Authorization** – *I hereby authorize PREVENTIVE CARDIOLOGY CONSULTANTS, P.A. to release medical information about me to the following Physician/Clinic:*_____

☐ **HIPAA Privacy Act** – *I have received the HIPAA Privacy Practice Act from PREVENTIVE CARDIOLOGY CONSULTANTS, P.A..*

☐ **Assignment of Benefits** – *I hereby assign the authorized benefits and direct that payment under any insurance policy or health benefits plan to be made directly to PREVENTIVE CARDIOLOGY CONSULTANTS, P.A. for any services rendered to me by or on behalf of PREVENTIVE CARDIOLOGY CONSULTANTS, P.A..*

☐ **Medicare Patients** – *I request that payment of authorized Medicare benefits be made either to me or on my behalf to PREVENTIVE CARDIOLOGY CONSULTANTS, P.A. for any services furnished me by that organization. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.*

☐ **Records Release to Insurance Carrier(s) and Other Payers** – *I hereby authorize PREVENTIVE CARDIOLOGY CONSULTANTS, P.A. to release to my insurance company, health plan, HMO, no-fault carrier, and/or workers' compensation carrier, any information including my complete health record needed to determine benefits for services provided by or on behalf of PREVENTIVE CARDIOLOGY CONSULTANTS, P.A..*

☐ ***"I understand that I am financially responsible for charges not covered under my insurance policy".***

FOR ALL OF THE ABOVE INFORMATION:

_____ _____
Signature Date