**NOTICE OF PRIVACY PRACTICES (PATIENT COPY)**

This Health Insurance Portability & Accountability Act of 1996 ("HIPPA") is a federal program that requests that medical records and other individually identifiable health information used or disclosed by using any form, whether electronically, on paper, orally, are kept properly confidential. This Act gives you, the patient, the right to understand and control how your personal health information ("PHI") is used. HIPPA provides penalties for the misuse of personal health information.

As required by HIPPA, we prepared this explanation of how we are to maintain the privacy of your health information and how email disclose your personal information.

We may use or disclose your 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 healthcare providers. An example of this would include referring you to a specialist.
- Payment means obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to any services offered.
- Health Care operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.
- The practice may also disclose your PHI for law enforcement and other legitimate reasons, although we shall do our best to ensure its continued confidentiality to the extent possible.

We may contact you by phone or email, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications that may be of interest to you. You do have the right to "opt. out" with respect or receive fundraising communication from us.

Disclosure of PHI will only be made pursuant our receiving a written authorization from you.



## Full Copy Is available online at getwellinternalmedicine.com

## If you would like a printed copy, please let our associate know.

## Please acknowledge receipt of notice by signing below.

**Patient Name**: _____ **Signature**: _____ **Date**: _____