COMPREHENSIVE DERMATOLOGY CENTER

NOTICE OF PRIVACY PRACTICES

The HIPPA policy was initially required by the Privacy Regulations Created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). We have revised HIPPA Policy based on the implement of the Department of Health and Human Services (HHS) Omnibus ruling in January 2013 that required to supplement and modify the privacy, security, breach notification, and enforcement governing patient health information in the original HIPPA.

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

We respect our legal obligation to keep health information that identifies your private. **We are required to notify you and report to HHS immediately if there a breach of your PHI.** We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

NEW UPDATE:

BUSINESS ASSOCIATES: Electronic Medical Record System Vendor (MDland) we have signed HIPPA agreement. The other potential associates: answering and billing services, independent transcriptionist, practice management consultants, attorneys and record shredding services and other vendors involved in creating or maintaining your medical records, are not used. If there is confidentiality breaches committed by our electronic vender, the vendor will be directly responsible for their own action, we will also have liability for the breach. We will notify you as well as report to Health and Human Services (HHS) immediately if any incident happens.

MORE PATIENT RIGHTS:
You will be able to restrict the PHI (Personal Health Information) such as a test or treatment for which you have paid out-of-pocket with your health insurance. You may also request copies of your electronic health records (that may involve costs based on the amount of documentation requested) within 30 days from the date of request with one 30-dayextension permitted.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS
The most common reason why we use or disclose your health information is for treatment, payment or health care operations. An example of how emergency room use or disclose information for treatment professional that you may have seen before

us. An example of how we use or disclose your health information for payment purposes is preparing and sending bills or claims. “Health care operations” mean those administrative and managerial functions that we have to do in order to run our office such as financial or billing audits or internal quality assurance.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for the above reasons, we will not ask you for special written permission.

USE AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- When a state or federal law mandates that certain health information be reported for a specific purpose;
- For public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- Disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- Uses and disclosures for health oversight activities, such as for licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violation of health care laws;
- Disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- Disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- Uses and disclosures to prevent a serious threat to health or safety;
- Uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign services;
- Disclosures of de-identified information;
- Disclosures relating to worker’s compensation programs;
- Disclosures of a “limited data set” for research, public health, or health care operations;
- Incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- Disclosures to “business associates” who perform health care operations for us and who commit to respond the privacy of your health information.

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your skin care.

APPOINTMENT REMINDERS

We may call or write to remind you of schedules appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your information unless you sign a written "authorization form." Federal law determines the content of an "authorization form".

If you do not sign the authorization, we cannot make use of disclosure of your information. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- Ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment) payment of health care operations. We do not have to agree to do this.
- Ask us to communicate with you in a confidential way.
- Ask us to see or to get photocopies of your health information according to federal regulation.
- Ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you asked us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write.
- Get a list of the disclosures that we may have made of our health information within the past six years if we use it for purposes other then treatment, payment of health care operations.
- Get additional paper copies of this Notice of Privacy Practices upon request.

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HIPAA CONSENT AGREEMENT

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) does not require that health care providers obtain a consent agreement in order to the use and disclose individually identifiable health information (IIHI), as long as it is only shared with others who are treating you or supporting us in providing you quality health care. We have updated HIPAA policy and we are in compliance with recent OMNIBUS rules.

It is our obligation, however, that to inform you and to have your consent to allow us to use/or disclose your IIHI to health care plans to ensure accurate and timely payments for the services we render. This requires that we inform you of our policy regarding the protection of your IIHI through our Privacy Notice. Please refer to our Privacy Notice (this documentation is available from the front desk) for a full explanation of how this office will protect your individually identifiable health information (IIHI).

Thank you for your confidence in our practice and for supporting our requirements.

The following is a statement that allows us to work within the requirement:
I have been offered an opportunity to review a Privacy Notice and I understand my rights regarding individually identifiable health information (IIHI). I consent to the use and /or disclose of my IIHI for purpose of treatment, payment or other health care operation. Other uses of my IIHI will require an authorization from me for the specific intention of disclosure.

_____
Patient Name

_____
Signature

_____/_____/_____
Date