

Notice of Privacy Acknowledgment

I acknowledge that I have been provided with and have had an opportunity to read a copy of the Notice of Privacy Practice for Gastroenterology Associates, PA

Patient Name

Date

Signature (Guardian, Parent, Responsible Party of above patient)

Date

You may discuss my condition/results with: _____

Relationship: _____

You may not discuss my condition/results with anyone.

You may leave messages concerning test results, appointments, my condition and diagnosis on my home voice mail, cell phone voice mail or personal e-mail.

E-mail address: _____

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

Notice of Privacy Practices of Gastroenterology Associates, PA

The Effective Date of this Notice is November 1, 2001

1. Gastroenterology Associates, PA (Practice) is required to maintain the privacy of patients' protected health information, provide this notice, and abide by the terms of the notice currently in effect. The Practice may amend the provisions of this notice upon vote of the shareholder physicians of the Practice and will inform patients pursuant to paragraph 13 of any changes to this notice.
2. The Practice may use your health information for the purposes of treatment, payment and health care operations. The Practice may provide you with appointment reminders so that you do not forget your next appointment, either by telephone or by mail or e-mail. The Practice may give you information about treatment alternatives; disclose your health information to your insurance company to obtain payment, to our billing company to process your treatment charges and payments, to physicians to whom you are referred or request a referral, and to other health care providers to further treatment.

For example: The Practice may disclose your diagnosis and the medical treatment rendered to you to a billing company and/or your health insurance. Additionally, the Practice may give information to your pharmacy about a prescription for your condition. This list and these examples are not exhaustive, but they provide you with some of the chief uses the Practice makes in disclosing private health information for treatment, payment and health care operations.

The Practice is permitted to use a patient's protected health information to perform research, to Disclosures which are required by law, for public health and safety and health oversight activities, Administrative and judicial proceedings, law enforcement, and in the case of death, without the patient's written consent or authorization.

You have the right to decline consent or authorization or to revoke consent or authorization at any time, but the Practice may refuse to render treatment or to provide further treatment if you decline consent or revoke consent. Additionally, if we have relied on your consent or authorization, the dissemination of your health information in reliance on your consent or authorization is permitted under the law. The Practice is not required to obtain your consent for purposes of a disclosure related to treatment, payment or health care operations in the event of emergency services, treatment of inmates in a correctional institution, or if the Practice is providing care to you under orders of another provider. When disclosing protected health information, the Practice will make reasonable efforts to limit the health information disclosed to the minimum necessary to accomplish the Practice's intended purpose, (except for treatment purposes, disclosures to individuals or other disclosures required by law) and the Practice will limit access to protected health information among staff to that which they need to know to accomplish their jobs. The Practice has implemented policies and procedures to safeguard protected health information within the Practice. If the Practice wishes to disclose protected health information for any other purpose, such as for marketing purposes, the Practice will first have to obtain your written and revocable authorization. You have the right to request restrictions on uses and disclosures of your protected health information for purposes of treatment, payment and healthcare operations, or restrictions involving your care, but the Practice is not obligated to comply with any of your requests in that regard. You have the right to receive confidential communications of your protected health information by alternative means and at alternative locations provided your requests are reasonable. You have the right to complain to the Practice or the Secretary of Health and Human Services regarding a privacy right violation. In order to communicate with the Practice about privacy, either to obtain further information about this notice, or to register a complaint, kindly see the receptionist and request a "Privacy Form" to fill out. When you have filled out the form, return it to her and she will deliver it to the Practice Chief Privacy Office for further action. The Practice will not retaliate against you if you register a privacy complaint. You have the right to request an accounting of the disclosures of your protected health information except disclosures for the purposes of treatment, payment and health care operations, and to inspect, copy/and or amend your protected health information, to the extent required and permissible under the law. Protected health information that is released to others may be redisclosed by the authorized recipient and may no longer be protected by the privacy rules of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). If you wish further information about the Practice's privacy policies, contact the Chief Privacy Officer at 738-5300. If there are any changes to the Practice's privacy policies that effect patients, this notice will be revised and the revised notice will be distributed to patients when the arrive for their next appointment.