Notice of Privacy Practices

This Notice of Privacy Practices describes how we may use and disclose your protected health information for medical treatment, payment, or health care operations, or for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. The use and disclosure of your PHI will follow this policy and is in accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The HIPAA Privacy Rule protects only certain medical information known as protected health information. “Protected health information,” or PHI, is information about you, including demographic information that may identify you and that relates to your past, current or future physical or mental healthcare services.

Our responsibility. We are required to abide by the Notice of Privacy Practices. We may change the terms of our notice at any time and will notify you of any changes.

Use and disclosure. Your PHI may be used and disclosed by your provider, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to obtain payment for your healthcare services, to support the operation of the provider’s practice and any other use required by law.

Treatment. We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes coordination of care with a third party, such as a referring medical specialist.

Payment. Your PHI will be used, as needed to obtain payment for your healthcare services.

Healthcare Operations. We may use or disclose, as needed, your PHI in order to support the business activities of our practice. These activities include, but are not limited to, quality improvement activities, employee review activities, licensing and conducting business activities.

We may also use or disclose your PHI in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases, Health oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers’ Compensation, Inmates, Required Uses and Disclosures; Under the Law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures: Will be made only with your consent, authorization, or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your provider or the provider’s practice has taken as action in reliance on the use or disclosure indicated in the authorization.

Updated 9-26-22

You have the right to inspect and copy your PHI. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI.

You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your PHI may be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Privacy Notice Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your provider is not required to agree to a restriction that you may request, unless the request restricts the disclosure of PHI related to care paid for out-of-pocket in full to health plans. If the provider believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another Healthcare Provider.

You have the right to request confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your provider amend your PHI. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

________ (initial) I am aware of the HIPAA Privacy Act and reviewed the above Notice of Privacy Practices.

________ (initial) I authorize Doxology Health and Fertility to disclose personal health information as necessary for continuous healthcare services to the following persons.

Name: ________________________________ Relationship: _____________ Phone: ____________

Name: ________________________________ Relationship: _____________ Phone: ____________

Name: ________________________________ Relationship: _____________ Phone: ____________

Name: ________________________________ Relationship: _____________ Phone: ____________

This notice was published and becomes effective on September 26, 2022.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to PHI. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

Name (please print) ____

Signature ____ Date __________________________