

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. This notice applies to all of the records concerning your care generated by the practice, whether made by the practice or an associated facility or doctor.

This notice describes our Practice's policies, which extend to any health care professional authorized to enter information into your chart; all areas of the Practice; all employees, staff and other personnel that work for or with our Practice; our business associates, on-call physicians, and so on.

The Practice provides this Notice to comply with the Privacy Regulations issued by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

WE ARE REQUIRED BY LAW TO

- Make sure that the protected health information about you is kept private;
- Provide you with a Notice of our Privacy Practices and your legal rights with respect to protected health information about you; and
- Follow the conditions of the Notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

MEDICAL TREATMENT - We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

PAYMENT - We may use and disclose your health information to obtain payment for services we provide to you.

HEALTH CARE OPERATIONS - We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

APPOINTMENT AND PATIENT RECALL REMINDERS - We may use and disclose medical information to contact you as a reminder that you have an appointment for medical care with the Practice or that you are due to receive periodic care from the Practice. This contact may be by phone, in writing, e-mail, or otherwise which could (potentially) be received or intercepted by others.

EMERGENCY SITUATIONS - In addition, we may disclose medical information about you to an organization assisting in a disaster relief effort or in an emergency situation so that your family can be notified about your condition, status and location.

FAMILY & FRIENDS - We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare.

RESEARCH - We do not disclose any identifying medical information about you for research purposes without your signed authorization. If the information has been de-identified, an authorization for the use or disclosure is not required.

REQUIRED BY LAW - We will disclose medical information about you when required to do so by federal, state or local law.

TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY - We may use and disclose medical information about you when necessary to prevent a serious threat either to your specific health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

ORGAN AND TISSUE DONATION - If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank as necessary.

PUBLIC HEALTH RISKS - Law or public policy may require us to disclose medical information about you for public health activities. These activities generally include the following: To prevent or control disease, injury or disability; to report births and deaths; to report child abuse or neglect; to report reactions to medications or problems with products; to notify people of recalls of products they may be using; to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

INVESTIGATION AND GOVERNMENT ACTIVITIES - We may disclose medical information to a local, state or federal agency for activities authorized by law. These activities include, for example, audits, investigations, inspections, and licensure.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU (2)

LAWSUITS AND DISPUTES - If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order or a subpoena, discovery request, or other lawful process by someone else involved in the dispute. We may also use such information to defend ourselves or any member of our Practice in any actual or threatened action.

LAW ENFORCEMENT - We may release medical information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process about a victim of a crime; about a death we believe may be the result of criminal conduct; about criminal conduct at the Practice; and in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

CORONERS, MEDICAL EXAMINERS AND FUNERAL DIRECTORS - We may release medical information to a coroner, medical examiner or funeral director.

INMATES - If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official.

CHANGES TO THIS NOTICE

We reserve the right to change this notice at any time and to make the revised or changed notice effective for medical information we already have about you as well as any information we may receive from you in the future. We will post a copy of the current notice in the Practice. Each time you visit the Practice for treatment or health care services you may request a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our office manager (850-234-7080), who will direct you on how to file an office complaint. All complaints must be submitted in writing, and shall be investigated, without repercussion to you.

YOU WILL NOT BE PENALIZED FOR FILING A COMPLAINT.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written authorization, unless those uses can be reasonably inferred from the intended uses above. You may revoke that authorization in writing, at any time. You understand that we are unable to take back any disclosures we have already made with your permission.

PATIENT RIGHTS

RIGHT TO INSPECT AND COPY: You have the right to inspect and copy medical information that may be used to make decisions about your care. This includes your own medical and billing records, but does not include psychotherapy notes. Upon proof of an appropriate legal relationship, records of others related to you or under your care may also be disclosed. To inspect and copy your medical record, you must submit your request in writing to our Compliance Officer. We may charge a fee for the costs of copying, mailing or other supplies (tapes, disks, etc.) associated with your request. We may deny your request to inspect and copy in limited circumstances. If you are denied access to medical information, you may request that our Compliance Committee review the denial. Another licensed health care professional chosen by the Practice will review your request and the denial. We will comply with the outcome and recommendations from that review.

RIGHT TO AMEND: You have the right to request that we amend your health information. Your request must be in writing and must explain why the information should be amended. We may deny your request under certain circumstances.

RIGHT TO AN ACCOUNTING OF DISCLOSURES: You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you, to others. To request this list, you must submit your request in writing. Your request must state a time period not longer than six (6) years back and may not include dates before April 14, 2003. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

RIGHT TO REQUEST RESTRICTIONS: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

RIGHT TO A PAPER COPY OF THIS NOTICE: You have a right to a paper copy of this notice at any time upon your request.

ACKNOWLEDGEMENT OF RECEIPT

OF NOTICE OF PRIVACY PRACTICES (YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT)

I, _____ have received a copy of this office's
Notices of Privacy Practices

SIGNATURE

DATE

AUTHORIZATION FORM FOR OTHER USES OF PROTECTED HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you pursuant to our general Patient Consent Form. On occasion, the patient and the Practice may want to use PHI for reasons other than treatment, payment and health care operations. This form summarizes the anticipated use of information about you for which this authorization is required. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

LIST OF INDIVIDUALS WHO MAY RECEIVE AND USE DISCLOSED INFORMATION

NAME

RELATIONSHIP

NAME

RELATIONSHIP

NAME

RELATIONSHIP

NAME

RELATIONSHIP

THE INDIVIDUALS WHO MAY USE OR DISCLOSE THIS INFORMATION ARE DR. MYERS AND EMPLOYEES

PLEASE SPECIFY WHAT TYPE OF INFORMATION CAN BE DISCLOSED TO ABOVE INDIVIDUALS

- ALL INFORMATION APPOINTMENT INFORMATION X-RAYS FINANCIAL INFORMATION
 MEDICAL RECORDS PERSONAL IDENTIFYING INFORMATION INSURANCE INFORMATION
 OTHER (SPECIFY) _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but could not be obtained because:

- INDIVIDUAL REFUSED TO SIGN COMMUNICATION BARRIERS PROHIBITED OBTAINING THE ACKNOWLEDGEMENT
 AN EMERGENCY SITUATION PREVENTED US FROM OBTAINING ACKNOWLEDGEMENT
 OTHER (SPECIFY) _____