Cary S. Kaufman MD, FACS – Notice of Privacy Practices

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.

USES AND DISCLOSURE

Our practice collects personal health information on you that may be used for three primary purposes:

1. Treatment – For example, we will prepare a record of information each time we see you in or out of the office while you are under our care. This medical record is used to keep track of changes in your condition as well as remind us of your past care, treatment, allergies and other facts relevant to your overall health. This information may be passed on to other providers as part of a coordinated health care program for you.
2. Payment – We must report elements of your personal health information, such as specific treatments, visits, tests and surgeries along with related diagnoses to third party payers to properly determine benefits payable on your behalf for the services we render. We only report the minimum necessary information to process the claim.
3. Health Care Operations – In order to provide you with high-quality health care we often need to be able to use your personal health information for purposes such as pre-registering you at the hospital if you ever need admission, or providing our pharmacy with a prescription so that it is ready to pick up when you arrive. Again, we are committed to using the minimum necessary information to achieve these purposes.

   In addition, we will use or disclose your personal health information under the following circumstances:

   a. When we receive a valid authorization from you
   b. If you give us an oral authorization
   c. If we are required by law to disclose your personal health information to others such as public health agencies.

REQUIRED DISCLOSURES

We are required to disclose the information to you if you request it and we are required to disclose the information to the US DHHS for compliance determinations of this practice. We may disclose information about you without your authorization for the following reasons:

1. When required by law, for judicial proceedings or law enforcement
2. For uses and disclosures about descendants
3. Uses and disclosures for cadaver tissue donation
4. To avert a serious threat to public health or safety
5. Disclosures about abuse or neglect or domestic violence

Other uses and disclosures will be made only with your written authorization and you may revoke such authorization by writing to us at our practice address or delivering a written revocation to us in person. We may periodically call you to remind you of appointments and we may advise you of treatment alternatives and benefits that may be of interest to you based on your health condition or status.

YOUR RIGHTS

1. You have a right to request restrictions on the use and disclosure of your PHI (personal health information). Our practice is not obligated to accept your restrictions though. However, if we do accept the restriction it must be complied with fully on our part.
2. You have a right to inspect and have a copy of your PHI. If you would like a copy please request the information in writing or use a form available in our office for the request.
3. You have a right to request amendments to your PHI. We will not amend any information we did not create. We are not obligated to make an amendment to your PHI but we will include your request for the amendment as part of your PHI.
4. You have a right to an accounting for the prior six years (but no earlier than the effective date of this notification) for uses and disclosure for purposes other than treatment, payment and health care operations of our practice.
5. You have a right to a paper copy of this notification. The current version will be provided to you at your request.

OUR DUTIES

1. We are obligated by law to protect your privacy and we will do our utmost to fulfil that duty to you. We will abide by all the terms in this notification but we reserve the right to change the terms of this notice and the personal health information it protects. You are entitled to a copy of these changes. We will include updated copies with statements mailed to patients, and we will have a current copy in our office at all times.
2. We will do our very best to make certain your rights are protected and we carry out our responsibilities to you. If you have any complaint we encourage you to contact us. It is our sincere desire to preserve your privacy and fulfill our duties. We will take no retaliatory action against any person for exercising their right to the resolution of a grievance. To the contrary we encourage your comments and criticisms. If we cannot resolve the issue for you, you have the right to file a grievance and make a complaint to the US Department of Health and Human Services.

To make a complaint or ask any questions concerning this policy, please contact the office manager directly at (360)-671-9877.

Effective Date: April 15, 2013

Cary S. Kaufman M.D., F.A.C.S.
2075 Barkley Blvd. Suite 250
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Patient Consent for Use and Disclosure of Protected Health Information

In signing this form, you consent to the use and disclosure of your protected health information by [practice], our staff, and our business associates strictly for the purpose of treatment, payment and health care operations.

You acknowledge you have had an opportunity to review our ***Notice of Privacy Practices*** prior to signing this consent. We encourage you to review our ***Notice of Privacy Practice***s carefully. It provides more detail on how we may use and disclose your information. The ***Notice of Privacy Practices*** may change. A current copy may be requested when you are being seen as a patient, or by contacting our manager at 360-671-9877.

You may request that we restrict how we use and disclose your protected health information for the purposes mentioned above. If you would like to request a restriction, please do so in writing. However, we reserve the right to deny your request. If we grant your request, we are bound by the terms of the agreement.

You may also revoke this consent in writing; however, information on any treatment/service provided using this or prior consents may still be used or disclosed for purposes of treatment, payment, or health care operations. Refer to the ***Notice of Privacy Practices*** for further information.

By signing this form, I grant my consent for the practice to use and disclose my protected health information for the purposes of treatment, payment and health care operations.

Signature of Patient or Surrogate Decision Maker: _____ **Date:** _____

Relationship to Patient/ Legal Authority *(if applicable)*: _____

For Practice use only

Failure to obtain consent Check the appropriate reason:

☐ **Indirect Treatment Relationship** ☐ **Emergency treatment**
☐ **Substantial Communication Barrier** ☐ **Refusal to Sign** ☐ **Other**

Description:

_____ _____
Practice Signature **Date**

_____ _____
Witness **Date**