HEALTHYSKIN DERMATOLOGY MEDICAL & COSMETIC

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 READ IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requests that all medical records and other individually identifiable health information used or disclosed by us is any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your protected health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers.
- During treatment, photographs may be used to identify you and your skin condition(s). These photographs are a permanent part of your electronic health record and are subject to the same privacy standards as the rest of your PHI.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.

Health care operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.

- The practice may also be required to disclose your PHI for law enforcement and other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other communications, that may be of interest to you. By providing your email address to us on the data sheet, you are subject to receiving email communications from us. You do have the right to "opt out" with respect to receiving email or other communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosures of psychotherapy notes.
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations.
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization.

You may have the following rights with respect to your PHI:

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request in limited circumstances. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services “out of pocket”, in full and in advance, and you request that we do not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your PHI and to provide the notice of our legal duties and our privacy practice with respect to PHI.

This notice is effective as of June 8, 2015, and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provision effective for all PHI that we maintain. We will post a copy and you may request a written copy of the revised Notice of Privacy Practices from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with the practice and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the practice Compliance Officer at 520.293.5757, for more information, in person or in writing.

HIPAA Consent

I hereby permit Sheftel & Associates Dermatology, LLP, dba HealthySkin Medical & Cosmetic Dermatology, to use my health information, and/or to disclose my health information to any third-party payor (health insurance company), or to any party involved in my health care. I understand that there is a Notice of Privacy Practices in the practice reception area available for me to read. This consent shall be in force and effect as long as I am a patient at this practice. I understand that I have the right to revoke this consent, in writing, at any time by sending such written notification to my physician(s) at this practice. I understand the information used or disclosed pursuant to this consent may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I also understand that I have the right to:

- *Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or states law to the extent the state law provides greater access rights).*
- *Refuse to sign the HIPAA Consent form.*

The HIPAA Consent & Receipt of Notice of Privacy Practices Acknowledgement will be signed electronically by you in the exam room. If you have any concerns regarding this consent, please address them with our front desk staff or our practice Compliance Officer prior to your appointment.