ENDOCRINE CONSULTANTS

HIPAA NOTICE OF PRIVACY PRACTICES

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

SUMMARY:

By law, we are required to provide you with our Notice of Privacy Practices (NPP.) This notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information. As a patient, you have the following rights:

1. **The right to request corrections to your information.**
2. **The right to request that your information be restricted.**
3. **The right to request confidential communications.**
4. **The right to a report of disclosures of your information.**
5. **The right to a paper copy of this notice.**
6. **The right to file a complaint if you feel that your privacy has been violated.**

We want to assure you that your medical/protected health information is secure with us. This Notice contains information about how we will ensure that your information remains private.

- **Abuse or Neglect – May disclose information when it concerns the abuse, neglect or violence in accordance to federal or state law.**
- **Coroner, Medical Examiner, or Funeral Director – May disclose information for identification of a body or determine cause of death.**
- **Food and Drug Administration – May disclose information to report adverse events, product recalls, to make repairs or replacements.**
- **Research – May disclose information for certain research purposes if an Institutional Review Board that has reviewed the research proposal and established protocols to ensure the privacy of your information {GA Code Ann.~31-7-6(b)}**
- **Disclosure to Department of Health and Human Services – May disclose information for public health purposed to help control diseases, injury or disability, also to a person who may have been exposed to a communicable disease or at risk of contracting or spreading a disease or condition.**
- **Others Involved in your healthcare – May disclose information to family members, other relatives, close personal friends or other representatives you have authorized when medical information is directly relevant to that person's involvement in your care.**
- **Health Oversight Activities – May disclose information for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee health care systems, government benefit programs and other government regulatory programs and civil rights law.**
- **Disaster Relief – May disclose information to the public entity, such as American Red Cross, for purpose of coordinating with the entity to assist in disaster relief efforts.**
- **Facility Directory – Unless you object, we will use and disclose in our facility directory under your name, and the location at which you are receiving care. This information will be disclosed only when someone calls and asks for you by name.**
- **Business Associates – May disclose information to a business associate that we have a contract with to provide services on our behalf. We require our business associates to appropriately safeguard the health information of our patients.**

We will not use or disclose your medical information for any purpose without your written authorization. Once given, you may revoke your authorization in writing at any time.

Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that I have received a copy of the Endocrine Consultants NOTICE OF PRIVACY PRACTICES. I understand that if I have questions or complaints regarding my privacy rights, that I may contact the person named as the Privacy Officer. I further understand that Endocrine Consultants will offer me updates to this NOTICE OF PRIVACY PRACTICES, should it be amended, modified or changed in any way.

_____

Patient or Representative Name (Please Print)

_____

Patient or Representative Signature **Date**

_____ Patient refused to sign

_____ Patient was unable to sign because _____

_____

Documented by

ENDOCRINE CONSULTANTS

AUTHORIZED PATIENT NOTIFICATION LIST

(REQUIRED FOR HIPAA) HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY

I authorize all Endocrine Consultants Physicians and/or whomsoever he/she may designate as his/her professional representative/assistant to discuss any aspect of my endocrine care, to include: appointments, tests, test results, surgical procedures, prescriptions and any other pertinent information pertaining to my care with the following designated people:

_____ _____

_____ _____

_____ _____

This document will be part of your permanent record. In the event that any of the selected representatives you have designated changes, if will be necessary to update our records with a written notification. You will need to state who you would like to have removed form or added to the Authorized Notification List.

_____ _____

Patient/Other person authorized to sign **Date**

_____ _____

Relation to above signature **Date**

_____ _____

Witness Signature **Date**