PRIMARY
MED CLINIC

Notice and Acknowledgement of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you may have access to this information. Please review it carefully.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment for health care operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses or Disclosures of Health Information for Treatment, Payment and Healthcare Operations

The following categories describe different ways that we use and disclose medical information. The information may be used in your care and treatment for the purpose of providing health care services to you, to pay your healthcare bills, to support the operation of the physician’s practice and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party.

Payment: We may use and disclose medical information about you to determine eligibility for benefits and to facilitate payment for treatment and services you receive from health care providers.

Healthcare Operations: We may use or disclose your medical information in order to support the business activities of your physician’s practice. We may use medical information in connection with quality assessment, submitting claims, for medical review, legal services, audit services and fraud and abuse programs.

As Required By Law: We will disclose medical information about you when required to do so by federal, state or local law. We may disclose information when required by a court order or subpoena.

No Other Uses or Disclosures without Your Written Authorization: Other disclosures will only be made with your consent, unless required by law. You may revoke this authorization at any time in writing.

Your Rights Regarding Medical Information About You

Your Right to Request Restrictions:

You may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for

notification purposes as described in this Notice of Privacy. You may request that we not use or disclose PHI for marketing or selling of PHI. You have the right to request that your PHI not be used for fundraising. Your request must state the restrictions and to whom the restrictions apply. This request must be in writing.

Your Physician is not required to agree to a restriction you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted.

Your Right to Inspect and Copy: You have the right to inspect and copy medical information. To inspect and copy the medical information that may be used to make medical decisions about you, you must submit in writing a request. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

Your Right to Amend: If you feel that the medical information about you is incorrect or not complete, you may ask the physician to amend the information. To request an amendment your request must be in writing and you must provide a reason that supports your request. In addition, we may deny your request.

Your Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" where such disclosure was made for any purpose other than treatment, payment or health care operations. This request must be submitted in writing. Your request must state a time period of no longer than 6 (six) years.

Your Right to Request Confidential Communications: You have the right to request that we communicate with you about your medical matters by alternative means or at an alternative location. This request must be in writing.

Your Right to be Notified if Your PHI has been breached. You have the right to know if there has been a security breach of your unsecured Protected Health Information by us or a Business Associate.

Your Right to Request Restrictions on disclosures to Health Plans. You have a right to request restrictions to disclosures to health plans for payment or healthcare operations regarding services where the individual has paid for the service out of pocket and in full. This information can be released only upon your written authorization.

All Other Uses and Disclosures. All other uses and disclosures of information not contained in this Notice of Privacy Practices will not be disclosed without your authorization. You may revoke your permission in writing at any time.

Your Right to a Copy of This Notice: You have the right to request a paper copy of this notice.

Changes: We reserve the right to change the terms of this notice at any time and to apply the revised notice to all individually identifiable health information that it maintains.

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Complaints: If you believe your privacy rights have been violated, you may file a complaint to us or to the U.S. Department of Health and Human Services Office for Civil Rights. All complaints must be in writing. You will not be penalized for filing a complaint.

Arizona Department of Health Services
150 N. 18th Avenue, Suite 450
Phoenix, AZ 85007

ACKNOWLEDGEMENT & SIGNATURE

Patient Legal Name:_____

Patient/Authorized Representative Signature: _____
Date: ____ / ____ / _____

If signed by an authorized representative:
☐ Parent ☐ Legal Guardian ☐ Power of Attorney ☐ Other: _____

Printed Name: _____