Facial Plastic Surgery: Edward Szachowicz, MD
7373 France Ave. S Suite 508
Edina, MN 55435

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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.

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

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

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

- Treatment means the providing, coordinating or managing of health care related services by one or more health care providers. An example of this would be sending records to the surgery center if you are a surgical patient.
- Payment means such activities as obtaining reimbursement for services, confirming contracts, billing or collection activities. An example of this would be sending a quote or a bill.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service. An example would be an internal quality assessment review.

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

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. 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 authorization.

Initials: _____

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures and protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a 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 from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain and we have the obligation to provide to you a paper copy of this notice from us at your first service delivery date.
- The right to provide and we are obligated to receive a written acknowledgement that you have received a copy of our Notice of Privacy Practices.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health and Human Services, Offices of Civil Rights, about violations of the provisions to this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

You may contact us at:

Facial Plastic Surgery Specialists
7373 France Avenue South, Suite 508
Edina, MN 55345
952-835-5665

You may contact the Department of Health and Human Services at:

The U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
202-619-0257
Toll Free: 1-877-696-6775

Initials _____

Notice of Privacy Practices Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment, directly or indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but that if you do agree, then you are bound to abide by such restrictions.

Patient Name: **«Person_First_Name» «Person_Middle_Name» «Person_Last_Name»**

_____ _____

Signature of Patient or Guardian Name of Guardian (please print)

Date:_____ _____

Relationship to patient

(For Office Use Only)

I attempted to obtain the patient's signature in recognition of his/her acceptance of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Reason:_____

_____

_____

Date: _____ Signature: _____

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