NOTICE OF PRIVACY PRACTICES
Dr. Connie A. Miller

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.

Under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), all medical records and other individually identifiable protected health information (PHI) of which we have knowledge must be kept confidential. All PHI used by us or disclosed by us is covered by this Act regardless of whether this PHI is in electronic, oral or paper form. Several new rights are granted to patients under this Act, allowing control over how your PHI is used, how you can access it, and in some cases amend it.

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

We may be assessed a penalty for any misuse or unauthorized disclosures of your personal health information as regulated by HIPAA.

This Notice of Privacy Practices is effective on January 1, 2017.

We are bound to abide by the terms of this notice and reserve the right to make revisions to this policy. Should revisions be made, you will be notified in writing, and a copy of the revised policy will be made available at your request.

Should any breach of unsecured PHI ever occur, we will notify the patient(s) involved within 10 business days of discovery of this breach.

You will be asked to sign a consent form authorizing us to use and disclose your personal health information only for the purposes of treatment, payment, and health care operations.

We may, without prior consent, use or disclose your PHI to carry out treatment, payment, or health care operations:

- Directly to you at your request
- In an emergency treatment situation
- To other healthcare providers involved in your treatment (directly and indirectly)
- Pursuant to and in compliance with an authorization signed by you
- Provided that you are informed in advance of the use and disclosure and have the opportunity to agree or to prohibit or restrict the use of disclosure (this may be an oral agreement between us)

All other uses and disclosures will be made only upon securing a written authorization form signed by you. You have the right to revoke this authorization, at any time, upon written notice and we will abide by that request. However, exception would be any actions already taken, relying on your authorization, and prior to revocation notice.
If you have paid for services out of pocket, in full, and request that we not disclose PHI related solely to the services to a health plan, we will abide by this request except where required by law to make a disclosure.
We may contact you to provide appointment reminders or to inform you about treatment alternatives or other health related benefits or services that may be of interest to you.

Under HIPAA, you have the following rights with respect to your protected health information:

- You have the right to request restrictions on certain uses and disclosures of protected health information, including restrictions placed upon disclosure to any persons you may identify. We are, however, not required to agree with a requested restriction
- You have the right to receive confidential communications of your protected health information, either directly from us or from us by alternative means
- You have the right to inspect and copy your protected health information; you may also request your PHI in an electronic format
- You have the right to amend PHI, however, this request may be denied under certain circumstances
- You have the right to receive an accounting of disclosures of your protected health information made by us in the six years prior to the date of the account request
- You have the right to obtain a paper copy of this notice from us, even if you have already agreed to receive the notice electronically

If you have any questions regarding your Protected Health Information, feel free to contact our Compliance Officer. By signing below, you consent to the use and disclosure of your protected health information by Dr. Connie A. Miller, our staff, and our business associates for treatment, payment, and health care operations.

Signed _____ Date _____
(Patient or Legal Guardian)

List any persons that are authorized to request PHI and other information concerning your care:

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship