NOTICE OF HIPAA PRIVACY PRACTICES

DR. FREEMAN & ASSOCIATES
3290 CHURCH ROAD, RICHMOND VA 23233

This notice describes how your health information may be used and disclosed and how you are allowed to access your health information.

OUR LEGAL DUTY:
Our office is required by law to maintain the privacy of your health information. Our office is required to give you this Notice about our privacy practices, our legal duties and your rights concerning your health information. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by law. You may request a copy of this Notice at any time.

USE OF DISCLOSURES OF HEALTH INFORMATION:
With your signed consent, we can use and disclose health information about you for treatment, payment and daily office operations. For Example:

TREATMENT: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you or consulting on your treatment.

PAYMENT: We may use or disclose your health information to obtain payment from you or your insurance providers for health services you have received.

DAILY OFFICE OPERATIONS: We may use or disclose your health information within our physical office location for the use of daily office operations such as scheduling appointments, relaying information to medical personal, and filing insurance.

APPOINTMENT REMINDERS: We may use or disclose your health information to provide you with appointment reminders such as voicemail, answering machines, postcards, letters, or e-mail.

YOUR AUTHORIZATION:
Unless you give us additional written authorization, we cannot use or disclose your health information for any reason except those described in this Notice. We must disclose your health information to you. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may disclose that information to that specific person. Copies of your healthcare records may only be released with your signature, and we will use our professional judgment in allowing a person, other than the patient, to pick up prescriptions, medical supplies, x-rays or other medical records.

PERSONS INVOLVED IN CARE:
We may use or disclose health information to notify a family member or the person responsible for your care, of your general condition. In the event of your incapacity or emergency circumstances, we will disclose health information based on our professional judgment and disclose only health information that is directly relevant to the person's involvement in your healthcare.

MARKETING:
Your health information will not be used for marketing communications with third party companies.

REQUIRED BY LAW:
We may use or disclose your health information when we are required to do so by law. We may disclose to military authorities the health information of Armed Forces personnel. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials health information of patients who are or becoming inmates.

ABUSE OR NEGLECT:
We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or the possible victim or other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health of safety or the health and safety of others.

PATIENT RIGHTS

ACCESS:
You have the right to review or receive copies of your health information. You must make a request in writing to obtain access to your health information. You may obtain a form to request such access from our office. If you request copies, there will be a charge of $10.00 for each chart copied (including x-rays) and an additional charge for postage if you want the copies mailed to you or another healthcare provider. This is a reasonable cost based fee for expenses such as copying, supplies, and staff time. No copies will be released until the fee is paid.

DISCLOSURE ACCOUNTING:
You have the right to receive a list of instances in which our office disclosed your health information for the purposes of treatment, payment, and healthcare operations, for the last six years, but not before April 14, 2003. If you request this accounting more than twice in a 12 month period, you will be charged a reasonable cost of $10.00 for each additional requests.

AMENDMENT:
You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS:
If you are concerned that we may have violated your privacy rights or you disagree with a decision we made about your right to access or to amend your health information, you may complain to us through our office Privacy Officer. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your compliant with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION:

Patient's Name: _____

By signing this form, you state that you have read, understand and agree to our office's Notice of HIPAA Privacy Policies and consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operation.

Patient's Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____ Date: _____
(Print)
Representative's Signature _____ Relationship to PT _____

I authorize the following individuals to have access to my medical records on my behalf:

_____ _____

_____ _____