Southwest CVA
Cardiovascular Associates

**CARDIOJOST, INC.**

## 04 - PATIENT RECORD OF DISCLOSURES - HIPAA

The "Health Insurance Portability and Accountability Act" *(HIPAA)* gives individuals the right to request a restriction on uses and disclosures of "Personal Health Information" *(PHI)*. The individual is also provided the right to request confidential communications of PHI be made by alternative means, such as correspondence to the individual's office instead of home.

The Privacy Rule generally requires Healthcare providers to take steps to limit their use or disclosure of your PHI. Healthcare entities must keep records of PHI disclosures.

*Note: Use and disclosure for emergencies may be permitted without prior consent.*

**I wish to be contacted in the following manner:** *(please check all that apply)*

☐ **Home Phone:** _____

☐ **Cell Phone:** _____

☐ **Work Phone:** _____

☐ **Fax Number:** _____

☐ **Other Phone:** _____

☐ **Okay to leave basic messages with callback number only.**

☐ **Okay to leave detailed messages with specific information.**

**Written & Electronic Communications:**

☐ **Okay to mail information to my home address.** *(See Patient Information Form for Address)*

☐ **Okay to mail information to my work/office address.** *(See Patient Information Form for Address)*

☐ **E-Mail:** _____ *(may not be secure)*

**The following individuals may have access to my "Personal Health Information" *(PHI)*:**

| NAME | RELATIONSHIP | PHONE NUMBER |
|---|---|---|
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| | | |
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### ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

†**By signing my name below, I acknowledge that I received a copy of this office's "NOTICE OF PRIVACY PRACTICES" outlining how my confidential "Personal Health Information" *(PHI)* will be used, disclosed and protected.**

† _____ _____

**PATIENT SIGNATURE** **DATE**

Save Form Print Form

# SOUTHWEST CARDIOVASCULAR ASSOCIATES

## 09 - NOTICE OF PRIVACY PRACTICES

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.

**SOUTHWEST CARDIOVASCULAR ASSOCIATES ARE DEDICATED TO MAINTAINING THE PRIVACY OF YOUR PERSONAL HEALTH INFORMATION. EACH TIME A PATIENT VISITS THIS OFFICE; A RECORD IS MADE THAT DESCRIBES THE TREATMENTS AND SERVICES PROVIDED. FEDERAL LAW OUTLINES SPECIFIC PRIVACY PROTECTIONS AND INDIVIDUAL RIGHTS RELATED TO THE INFORMATION WE MAINTAIN THAT IDENTIFIES YOU AS A PATIENT. PROTECTED INFORMATION INCLUDES DEMOGRAPHIC DATA AND FACTS ABOUT YOUR PAST, PRESENT, OR FUTURE PHYSICAL OR MENTAL HEALTH. OUR OFFICE HAS PUT IN PLACE POLICIES AND PROCEDURES TO HELP PROTECT YOUR HEALTH INFORMATION. WE ARE REQUIRED TO PROVIDE THIS NOTICE OUTLINING OUR LEGAL DUTIES AND RESPONSIBILITIES RELATED TO THE USE AND DISCLOSURE OF PATIENT IDENTIFIABLE HEALTH INFORMATION, PRIVACY PRACTICES AND EXAMPLES OF HOW YOUR INFORMATION MAY BE USED OR DISCLOSED.**

**PRACTICE WILL ABIDE BY THE TERMS OF THIS NOTICE. WE MAY REVISE THIS NOTICE AT ANY TIME. THE NEW NOTICE WILL BE POSTED IN OUR OFFICE IN A PROMINENT LOCATION. YOU CAN REQUEST A COPY OF OUR MOST CURRENT NOTICE AT ANY TIME. REVISIONS TO THE NOTICE WILL BE EFFECTIVE FOR ALL HEALTH CARE INFORMATION THIS OFFICE MAINTAINS: PAST, PRESENT OR FUTURE.**

**PRACTICE MAY USE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION FOR THE FOLLOWING PURPOSES WITHOUT YOUR AUTHORIZATION:**

1. TREATMENT: WE MAY USE AND DISCLOSE YOUR IDENTIFIABLE HEALTH INFORMATION TO TREAT YOU AND ASSIST OTHERS IN YOUR TREATMENT. FOR INSTANCE, WE MAY SEND A COPY OF YOUR RECORDS TO ANOTHER DOCTOR SO THAT YOU CAN BE EVALUATED FOR A SPECIFIC CONDITION, OR WE MAY DISCLOSE INFORMATION TO OTHERS WHO TAKE PART IN YOUR CARE, SUCH AS YOUR SPOUSE, CHILDREN OR PARENTS.

2. PAYMENT: WE MAY USE YOUR HEALTH INFORMATION TO BILL AND COLLECT PAYMENT FOR SERVICES PROVIDED. THIS MAY INCLUDED PROVIDING YOUR INSURANCE COMPANY WITH DETAILS OF YOUR TREATMENT, SHARING OUR PAYMENT INFORMATION WITH OTHER TREATMENT PROVIDERS, CONTACTING YOU OVER THE PHONE OR THROUGH THE MAIL ABOUT BALANCES, OR SENDING UNPAID BALANCES TO A COLLECTION AGENCY.

3. HEALTH CARE OPERATIONS: WE MAY USE AND DISCLOSE HEALTH INFORMATION TO OPERATE OUR BUSINESS. FOR EXAMPLE, YOUR HEALTH INFORMATION MAY BE USED TO EVALUATE THE QUALITY OF CARE WE PROVIDE, FOR STATE LICENSING, OR TO IDENTIFY YOU BY NAME WHEN YOU VISIT THE OFFICE.

4. APPOINTMENT REMINDERS: WE MAY USE AND DISCLOSE YOUR INFORMATION TO REMIND YOU OF APPOINTMENTS. WE MAY ALSO MAIL YOU A REMINDER POSTCARD FOR FOLLOW-UP VISITS.

5. TREATMENT OPTIONS: WE MAY USE YOUR HEALTH INFORMATION TO INFORM YOU OF TREATMENT OPTIONS OR OTHER HEALTH RELATED SERVICES, WHICH MAY BE OF INTEREST TO YOU.

6. BUSINESS ASSOCIATES: WE MAY SHARE YOUR HEALTH INFORMATION WITH OTHER INDIVIDUALS OR COMPANIES THAT PERFORM VARIOUS ACTIVITIES FOR, OR ON BEHALF OF, OUR OFFICE SUCH AS AFTER HOUR'S TELEPHONE ANSWERING, BILLING, OR QUALITY ASSURANCE. OUR BUSINESS ASSOCIATES AGREE TO PROTECT THE PRIVACY OF YOUR INFORMATION.

7. RESEARCH: WE MAY USE YOUR INFORMATION IN CONJUNCTION WITH AGENTS OF THE PRACTICE WHO MAY BE REQUIRED TO REVIEW YOUR FILES, JUST AS OUR EMPLOYEES ARE SO PERMITTED, IN ORDER TO DETERMINE WHETHER YOU ARE QUALIFIED FOR A RESEARCH PROJECT. IF YOU ARE ASKED TO JOIN A RESEARCH PROJECT, YOU WILL BE ASKED FIRST TO EXECUTE AN AUTHORIZATION, GRANTING THE PRACTICE OR A RESEARCH ORGANIZATION THE RIGHT TO USE YOUR PROTECTED HEALTH INFORMATION.

Practice may disclose your health information without your authorization when permitted or required to by law, including:

- For public health activities including reporting of certain communicable diseases.
- For workers' compensation or similar programs as required by law.
- To authorities when we suspect abuse, neglect or domestic violence.
- To health oversight agencies.
- To your employer if we provide health care services to you at the request of the employer, whereupon we shall provide you written notice of release of such information.
- For certain judicial and administrative proceedings pursuant to an administrative order.
- For law enforcement purposes.
- To a medical examiner, coroner or funeral director.
- For the facilitation of organ, eye or tissue donation if you are an organ donor.
- For research purposes under strict limited circumstances.
- To avert a serious threat to your health and safety or that of others.
- For governmental purposes such as military service or for national security.
- In the event of an emergency or for disaster relief.
- In any other instance required by law.
- Sign in sheet.

Practice may also disclose your information to family members and/or other persons involved in your care or payment for your care. Practice may leave messages for you at home or work about your visits. If you do not want us to do so, please inform our Privacy Officer in writing.

All other uses and disclosures of your information to others will require a written, signed authorization from you. You have the right to revoke your authorization at any time except to the extent that we have already acted on it. Should you require your records to be released, Practice will provide you with an authorization form to complete and return to the address listed on it.

Your health record is the physical property of practice. The information contained in it belongs to you. Below is a list of your rights regarding individually identifiable health information. All requests related to these items must be made in writing to our privacy officer at the address listed below. We will provide you with appropriate forms to exercise these rights. We will notify you, in writing, if your requests cannot be granted.

1. Restrictions on Use and Disclosure: You have the right to request restrictions on how we use and disclose your health information. This includes requests to restrict disclosure of our health information to only certain individuals, or entities, involved in your care such as family members and insurance companies. We are not required to agree with your request. If we agree, we are bound to the agreement unless disclosure is otherwise required or authorized by law.
2. Confidential Communication: You have the right to request that we communicate with you in a particular manner or at a certain location. For example, you may request that we only contact you at home. We will accommodate reasonable requests.
3. Access: You have the right to inspect or request a copy of records used to make decisions about your health care, including your medical chart and billing records. This office will schedule appointments for record inspection. We may charge a fee for providing you copies of your records. Under special circumstances, we may deny your request to inspect and/or copy of your records. You may request a review of this denial.
4. Record Amendment: You have the right to request amendments to your health records created by and for this Practice if you feel they are incorrect or incomplete. We may accept or deny your request. If we deny your request, you have the right to provide a statement of disagreement or rebuttal statement.
5. Accounting Disclosures: You have the right to receive an accounting of the disclosures. This means you may request a list of certain disclosures Practice has made of your records. Upon your request, we will provide this information to you one time free during each twelve (12) month period. There may be a fee for additional copies.
6. Copy of Notice: You have the right to request that we provide you with a paper copy of this notice of Privacy Practices.

If you have any questions about this notice, please contact the Practice's Privacy Officer: Alisa Jost at 480-945-4343.