HIPAA NOTICE of PRIVACY PRACTICES

At Dermatology Associates of Plymouth Meeting, we are committed to treating and using protected health information about you responsibly. This notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This notice is effective, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit Dermatology Associates of Plymouth Meeting, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for the future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Dermatology Associates of Plymouth Meeting, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request.
- Inspect and copy your health record.
- Amend your health record.
- Obtain an accounting of disclosures of your health information.
- Request communications of your health information by alternative means or at alternative locations.
- Request a restriction on certain uses and disclosures of your information.
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Dermatology Associates of Plymouth Meeting is required to:

- Maintain the privacy of your health information,
- Provide you with the notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us. We will not use or disclose your health information without your authorization, except as described in this notice. We will discontinue using or disclosing your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Human services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Ave. S.W., Room 509F, HHH Building, Washington, D.C. 20201.

Acknowledgement of Receipt of Privacy Notice

I hereby acknowledge that a copy of the "Notice of Privacy Practices" is available for my review, and I may receive a copy upon request.

Sign_____ Date_____ Print Name _____

Please allow access to my Protected Health Information (PHI) which includes billing and medical records to my (circle as many as apply):

Spouse Child Parent Guardian Other

Name _____Date _____Relationship_____

Patient Signature _____Date _____Print Name_____

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