

## HIPAA / NOTICE OF PRIVACY PRACTICES & CONSENT FORM

We are required by law to keep health information confidential. Authorization for the disclosure of health information to someone who is not legally required to keep it private may cause the information to no longer be protected by state and federal confidentiality laws. In accordance with state and federal patient privacy laws, including HIPPA (the Health Insurance Portability and Accountability Act of 1996), this Notice describes how your health information may be used or disclosed and how you, the patient, can get this information. Please review this Notice carefully.

PERMITTED USES & DISCLOSURES: The law permits us to use or disclose your health information to the following:

- Another specialist or physician who is involved in your care.
- Your insurance company, for the purpose of obtaining payment for our services.
- Our staff, for the purpose of entering your information into our computerized system.
- Other entities during the course of your treatment, in order to obtain authorizations, referral visits, scheduling of tests, etc. Much of this information is sent via fax, which is a permitted use allowed by law. We have on file with these sources verification for the confidentiality of the fax used and its limited access by authorized personnel.
- If this practice is sold, your health information will become the property of the new owner.
- We may release some or all of your health information when required by law. Except as described above, this practice will not use or disclose your health information without your prior written authorization.

Federal and state law allows us to use and disclose our patients' protected health information in order to provide health care services to them, to bill and collect payments for those services and in connection with our health care operations. We also use a shared Electronic Medical Record that allows both our physicians and staff access to our patients' health information. The purpose for this access is to expedite the referral of patients within the Camino Ear, Nose & Throat Clinic, other providers, and to assist in providing and managing their care in a coordinated way. Information in the Electronic Medical Record can be released outside the Camino Ear, Nose & Throat Clinic only with the patient's express authorization or as otherwise specifically permitted or required by law.

PATIENT RIGHTS: The law also establishes patient rights and our responsibility to inform you of those rights. These include:

- You have the right to request in writing any uses or disclosures we make with your health information beyond the normal uses referenced above.
- You have the right to limit the use or restrict the use disclosure of your health information. Our office will follow any restrictions notated by you on page 2 of this Form.
- You have the right to request in writing to inspect and receive a copy of your health information.\* Our office
  may charge a reasonable fee to cover copying and mailing of these records to you. Some releases of your
  health information may require the completion and submission of a separate request or form from this one,
  as our Privacy Officer may determine.



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- You have the right to request an alternate means or location to receive communications regarding your health information.\* Otherwise, such communications will be mailed to the home address in your medical or billing record or sent to the alternative address or by the alternative means of communication(s) you designate below (e.g., via telephone text or email).
- You have the right to request in writing an amendment or change to your health information. Our office may agree or disagree with your written request, but we will be happy to include your statement as part of your records. If an agreement to amend or change is acceptable, please be advised that previous documentation is considered a legal document and cannot be deleted or removed. Our office will simply notate the amendment and the reason for it and add it to your records.
  - \*Conditions and limitations may apply; obtain additional information from our Privacy Officer.
- We may use your information to contact you. For example, we may use the U.S. Mail, the telephone, a text message or email to remind you of an appointment or call you with information regarding your care. If you are not at home, this information may be left on your answering machine or voicemail, sent via text or email or left with the person who answered the phone. In an emergency, we may disclose your health information to a family member or another person designated responsible for your care.
- MINORS: We take patient privacy laws very seriously. The State of California limits what type of health
  information we can share with the parents or legal guardians of minor teenage children between the ages
  of 12 and 17. Accordingly, we will maintain an exclusive phone number and email address for minors in this
  age range, as they may designate.

PATIENT IS A MINOR, PLEASE STATE AGE:	AND DATE OF BIRTH:
including, but not limited to, corresponde	om our offices CAN disclose your health information to, nce, test results, prescriptions, medical records or billing checking the boxes below and signing below:
is authorization to Release Health Information is vo	oluntary.
aa amuliaabila.	dress, phone number and email address of Spouse,
	ternative address, phone numbers and email addresses of
• • • • • • • • • • • • • • • • • • • •	ncial Advisor, Legal Guardian, Conservator, or other legally st name(s), <u>alternative address, phone numbers, and email</u>
	including, but not limited to, corresponde information, who are 18 years or older, by is authorization to Release Health Information is voor oK to Spouse: Please list name, alternative ad as applicable:  OK to Family Members: Please list name(s), alternative Member(s), as applicable:  OK to Other (e.g., Attorney, Accountant, Finan authorized agent or representative). Please list



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<ul> <li>OK to leave health information on answering mach</li> </ul>	ine, voicemail, telephone text or email.
<ul> <li>DO NOT RELEASE AND SEND ANY INFORMATION to Please send my information to my home address or and email address I list here:</li> </ul>	· · · · · · · · · · · · · · · · · · ·
Address:	Phone:
Email Address:	
IF PATIENT IS A MINOR, PLEASE STATE AGE:	AND DATE OF BIRTH:
DO NOT RELEASE TO:	
We reserve the right to change our privacy practices and the conotice. In the event of changes, an updated notice will be post writing. You have the right to file a complaint with the Departr Avenue, S.W., Room 509F, Washington, DC 20201. Our office will However, before filing a complaint, or for more information or please contact our Privacy Officer at (925) 627-3424.	ted, and our office will notify you of the changes in ment of Health and Human Services, 200 Independent ill not retaliate against you for filing a complaint.
ACKNOWLEDGEMENT, AUTHORIZATION & CONSENT	
This acknowledges that you have received and read a copy of disclosure of your health information to the person(s) or entition remain as part of your medical and billing record.	•
Signature:	Date:
Patient's Name:	Date of Birth:
If the person signing is not the patient, please provide your/th and in what capacity you/they are signing (e.g., parent, guardia	· · · · · · · · · · · · · · · · · · ·
Name:	
Capacity and/or Relationship to Patient:	
This authorization/consent may be revoked at any time prior to The revocation must be in writing, signed by the patient or the to Camino Ear, Nose & Throat Clinic at their address referenced	eir authorized representative and delivered
Patient's authorized representative is entitled to receive a copy	y of this Authorization.
EXPIRATION OF AUTHORIZATION/CONSENT: Unless otherwise	revoked, rescinded, revised, updated or changed

by you in a writing signed by you, this Authorization & Consent shall not expire and will last indefinitely.