AMAR MEDICAL ASSOCIATES

PATIENT NAME: _____

I authorize Amar Medical Associates to leave a message on my home phone, cell phone, work phone, or with a family member.

Phone numbers where you may be reached:

_____ Home / Cell

_____ Home / Cell

Please initial below the type of follow-up you want with our office:

- ❏ Leave me a message to confirm/change appointments or provide test/lab results.
- ❏ Do not leave me a message, I will contact the office myself.
- ❏ Do not discuss my medical history with the following person(s):

_____

_____

_____

- ❏ The following person(s) has my permission to discuss my medical history with you:

NAME:	PHONE:	RELATIONSHIP:
_____	_____	spouse / child / father / mother / other
_____	_____	spouse / child / father / mother / other

I have read and signed the HIPPA Guideline Privacy Act on the reverse side of this paper and may request a copy at any time. Please note if a copy of medical records are requested, the patient must sign a medical release form.

_____	_____	_____
SIGNATURE OF PATIENT OR REPRESENTATIVE	PRINT NAME	DATE

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination, hearing test, allergy testing, and or injection.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

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

This notice is effective as of April 14, 2004, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy from this office. Amar Medical Associates *Main Office*: Hillcrest Professional Medical Building, 15247 11th Street, Suite 200, Victorville, CA 92395, ph. (760) 245-8645 and *Satellite Office*: Mercado Mall, 222 E. Main Street, Suite 201, Barstow, CA, 92311, ph. (760) 256-8569.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with our office first at the above address, and or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. The U.S. Department of Health &Human Services, Office of Civil Rights, 200 Independence Avenue, S.W., Washington, D.C. 20201.

PATIENT COPY