



ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES AND OFFICE POLICIES

Please print and read this document, sign the Signature Page at the end, and bring it with you to your New Patient Appointment.

Notice of Privacy Practice for Protected Health Information

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read this carefully.

With your consent, the practice is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment and health-care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination, test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for these services.

Your Health Information Rights

The health record we maintain and billing records are the physical property of the practice. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to the office. We are not required to grant the request but we will comply with any request granted.
- Request that you be allowed to inspect and copy your health record and billing record – you may exercise this right by delivering the request in writing to the office.
- Appeal a denial of access to your protected health information except in certain circumstances.
- Request that your healthcare record be amended to correct incomplete or incorrect information by delivering a written request to the office.
- File any statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all full disclosures of your protected health information.
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to the office. An accounting will not include internal uses of information for treatment, payment or operations,

disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care.

- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to the office.
- Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to the office.

If you wish to exercise any of the above rights, please contact Dr. Lisa Schwartz in person or in writing, during normal hours. She will provide you with assistance on the steps to take to exercise these rights.

Responsibilities of Dr. Lisa Schwartz

The practice is required to:

- Maintain the privacy of your health information as required by law.
- Provide you with a notice of our duties and privacy practices as to the information we collect and maintain about you.
- Abide by the terms of this notice.
- Accommodate your reasonable requests regarding methods to communicate health information with you. Dr. Lisa Schwartz reserves the rights to amend, change, or eliminate provisions in its privacy practices and access practices and to enact new provisions regarding the protected health information maintained here. If the information practices change, this notice will be amended. You are entitled to receive a revised copy of this notice by calling and requesting a copy of our "Notice" or by visiting the office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact Dr. Lisa Schwartz. Additionally if you believe your privacy rights have been violated, you may file a written complaint at the office by delivering the written complaint to Dr. Lisa Schwartz. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services whose street address and email address is 200 Independence Ave, SW, Washington, DC 20201 and HHS.mail@HHS.gov. We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the practice. We cannot, and will not, retaliate against you for filing a complaint with the Secretary.

Other Disclosures and Uses Notification

Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Communication with Family

Using our best judgment and professionalism, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Food and Drug Administration (FDA)

We may disclose to the FDA your protected health information relating to adverse events with respect to products and product defects, or post-marketing surveillance information to enable product recalls, repairs or replacements.

Workers Compensation

If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health

As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Abuse and Neglect

We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Correctional Institutions

If you are an inmate of a correctional institution, we may disclose to the institution, or its agents, your protected health information necessary for your health and health and safety of other individuals.

Law Enforcement

We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, during cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

Health Oversight

Federal law allows us to release your protected health information to appropriate health oversight agencies over health oversight activities.

Judicial/Administrative Proceedings

We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.

Other Uses

Other uses and disclosures besides those identified in this notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.

Research

We may disclose information to researchers when institutional review board has reviewed a research proposal, approved the research and establish protocols to insure the privacy of your protected health information.



**ACKNOWLEDGEMENT OF RECEIPT OF
PRIVACY PRACTICES AND OFFICE POLICIES**

SIGNATURE PAGE

1. I have read the information about e-mail procedures and privacy and have received answers to all of my questions about using e-mail to communicate with Dr. Lisa Schwartz.
2. I understand that email is never appropriate for urgent or emergency situations.
3. I understand that email sent to Dr. Schwartz from any email is considered insecure and I assume all responsibility for any misuse or misdirection of personal health information contained in such e-mails.
4. I have read the **Office Policies** of Dr. Lisa Schwartz (available at www.doctorlisaschwartz.com/policies.html) and have received answers to all of my questions regarding the contents therein. I agree to the terms set out in the Office Policies described above.
5. I have read the **Notice of Privacy Practice for Protected Health Information** of Dr. Lisa Schwartz (above) and have had all of my questions answered regarding the contents therein.

Print Name: _____

Date of Birth: _____

Signature: _____ Date: _____