

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

- Your Confidential Healthcare Information may be released to other healthcare professionals within this practice for the purpose of providing you quality healthcare.
- Your Confidential Healthcare Information may be released to your insurance provider to obtain payment for services provided to you.
- Your Confidential Healthcare Information can only be disclosed to you. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but **only** if you give us a written authorization.
- Your Confidential Healthcare Information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic violence
- Your Confidential Healthcare Information may be released to other healthcare providers in the event you need emergency care.
- Your Confidential Healthcare Information may be released to a public health organization or federal organization in the event of a communicable disease or to report a defective device or untoward event to a biological product (food or medication).
- Your Confidential Healthcare Information may not be released for any other purpose that which is identified in this notice.
- Your Confidential Healthcare Information may be released only after receiving written authorization from you. You may revoke your permission to release confidential healthcare information at any time.
- You may be contacted by the practice to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you.
- You may be contacted by the practice for the purposes of raising funds to support the practice's operations.
- You have the right to restrict the use of your confidential healthcare information. However, the practice may choose to refuse your restriction if it is in conflict of providing you with quality healthcare or in the event of an emergency situation.
- You have the right to receive confidential communication about your health status.
- You have the right to review and photocopy any/all portions of your confidential healthcare information. If you request copies of your health information we will charge you \$1.00 for each page, a \$16.00 administration fee for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. For more information, contact our HIPAA Compliance Officer listed below.
- You have the right to make changes to your confidential healthcare information.
- You have the right to know who has accessed your confidential healthcare information and for what.
- This practice is required by law to protect the privacy of its patients. It will keep confidential any and all patient healthcare information and will provide patients with a list of duties or practices that protect confidential healthcare information.
- You have the right to complain to this practice if you believe that your rights to privacy have been violated. If you feel that your privacy rights have been violated, please mail your complaint to our HIPAA Compliance Officer:

ATTN: HIPAA Compliance Officer

Orlandis Wells, MD.

129 W. Lake Mead Hwy. Suite 19

Henderson, NV 89015

- All complaints will be investigated. No personal issue will be raised for filing a complaint with this practice.
- For further information about this Notice of Privacy Practices, please contact the privacy officer.

THIS NOTICE WAS PUBLISHED AND IS EFFECTIVE AS OF MAY 24, 2006.

This practice will abide by the terms of this Notice. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. Before we make a significant change in our Privacy Practices, we will change this Notice. You may request a copy of our Notice at any time.

Acknowledgement of Privacy Practices

I hereby acknowledge that I have received a copy of this practice's **NOTICE OF PRIVACY PRACTICES**. I understand that if I have any questions or complaints regarding my privacy rights that I may contact the person listed above.

Patient or Representative Name (please print): _____

Patient or Representative Signature: _____ Date: _____

Patient refused to sign Patient was unable to sign because _____

