Phillips Clinic
Be well. Stay well. Age well.

5970C S. Rainbow Blvd. Suite 100
Las Vegas, Nevada 89118
(P) 702-363-4000
(F) 702-362-0086
www.phillipscliniclv.com

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your access and control of your protected health information. "Protected Health Information" is information about you including the demographic information that may identify you and that relates to your past, present or future physical or mental health condition and related to health care services.

USES AND DISCLOSURES OF "PHI"

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physicians practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your "PHI," as necessary, to a home health agency that provides care to you or to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose and treat you.

Payment: Your "PHI" will be used as needed to obtain payment for your health care services.

Health care operations: We may use or disclose, as needed, your "PHI" in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of employees or medical students, licensing etc… In addition, we will use a sign-in sheet at our registration desk where you will be asked to sign your name, indicate the time, whether or not you are a new patient, and whether your information has recently changed. We may also call you by name in the waiting room when we are ready to escort you to an exam room. We may use your "PHI" to contact you by telephone to remind you of an appointment. We may contact you via telephone to notify you of test results. If we are unable to contact you, we may leave a message on your telephone, with a family member, or with a friend for you to contact the office *unless you object*. We may mail reminders to your home regarding appointments. We may fax your "PHI" to referring physicians, hospitals, pharmacies, or third-party payers.

Our patient information sheet will require a patient or patient representative signature for consent for treatment, authorization to bill a third-party payer, and/or consent for financial responsibility.

We may use your "PHI" in the following circumstances *WITHOUT* your authorization: as required by law, public health issues, health oversight, abuse or neglect, food and drug administration requirements, disaster relief, legal proceedings, law enforcement, coroners, funeral directors, organ donations, research, criminal activity, military activity and national security, worker's compensation,

inmates, required uses and disclosure.

Under the law, we must make disclosures to you an when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the required of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES: will be made only with your consent, authorization, and opportunity to object unless required by law.

You may revoke this authorization at any time, in writing except to the extent that your physician or the physicians practice has taken an action in reliance on the use or disclosure indicated in this authorization.

Your Rights:

- **You have the right to inspect and copy your "PHI."**
- **You have the right to request a restriction of your "PHI."**
- **You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper notice of this notice from us.**
- **You have the right to have your physician amend your "PHI."**
- **You have the right to receive an accounting of certain disclosures we have made, if any, of your "PHI."**

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our privacy contact of your complaint. **WE WILL NOT RETALIATE AGAINST YOU FOR A COMPLAINT.**

This notice was published before and became effective on April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA compliance officer in person or by telephone.

Your signature below is an acknowledgement that you have received this Notice of our Privacy Practices.

Patient Name: ______________________________

Date of Birth: ______________

Patient's Signature or Representative's: ______________________________

Date: ______________

If signing by patient's representative please indicate relationship: ______________

Authorization for Use or Disclosure of Protected Health Information

I hereby request and authorize you to release the following records (please check all that apply):

☐ All medical records concerning my care and treatment rendered by you, except those relating to:
____ or

☐ Dates for service: ______________ to ______________

To the following individuals: ______________________________

Important: I understand that unless I specifically request that such information not be disclosed, authorized disclosure may contain PHI containing diagnosis, treatment and other information regarding psychiatric and mental health, substance abuse, chemical dependency, HIV and/or AIDS.

The Protected Health Information indicated above is to be used and/or disclosed for the following purpose(s):

☐ Continuity of Care ☐ Reimbursement ☐ Self ☐ Other: ______________

To be read by patient prior to signing:

- I understand that I may refuse to sign this authorization.
- I understand that my treatment by Phillips Clinic or payment for treatment will not be affected if I do not sign this form.
- I understand that I may request to inspect and copy the PHI that is to be used and/or disclosed pursuant to this authorization
- I understand that I should receive a copy of this authorization form after I sign it.
- I understand that if I authorize release of my PHI to a person or organization that is not subject to federal law governing privacy and that person or organization re-discloses my PHI, my PHI may no longer be protected by federal privacy laws.
- I understand I may revoke this authorization at any time by notifying Phillips Clinic in writing, at the above address, but that any such revocation will not have any effect on any actions that Phillips Clinic took before receiving the revocation.
- This authorization expires one year from the date signed if I have not provided an event (above) or and expiration date here: ______________

A photo static copy of this authorization shall be considered as effective and valid as the original.

______________________________ ______________

Signature of Patient or Representative Date

If signing by patient's representative please indicate relationship: ______________