Charles A. Wallace, M.D.
Notice of Privacy Practices: Use and Disclosure of Health Information Protected under HIPAA

This document provides a summary of how medical information about you may be used and disclosed and how you can obtain access to this information.

We understand that medical information about you and your health is personal. We are committed to protecting your medical information. It is our policy that the privacy of your protected health information (PHI) be uncompromised while still allowing necessary access to assure that the medical care you receive is appropriate and of the highest possible quality.

We pledge to you that we will protect the confidentiality of information provided to us. Your information will be used in the following manner, known as Treatment, Payment, and Healthcare Operations (TPO):

1. To provide medical treatment and/or services,
2. To bill third party payers, when appropriate, for treatment you receive from us.
3. To facilitate the mechanisms which allow the operation of our facility.

In every use of your information, we will be responsible custodians of your PHI and adhere to the standards set forth in the legislation which created these privacy practices. We recognize that all patients have the right to privacy in matters relating to their health and we will not use your PHI for uses outside of our facility without your express permission.

You have the following rights regarding to the medical information we maintain about you:

1. To inspect and copy information that may be used to make decisions about your care.
2. To request restrictions or limitations on the medical information we use or disclose about you for treatment, payment, or healthcare operations. While we are not required to agree to your request, we will do our utmost to comply unless the information is needed to provide emergency treatment.
3. To amend the PHI we maintain if you believe that the medical information we have about you is incorrect or incomplete.
4. To request an accounting of disclosures we have made for uses other than our own.
5. To request confidential communications; i.e., that we communicate with you in a certain manner or at a certain location.
6. To receive a paper copy of this notice.

All members of our staff are committed to adhering to the conditions set forth in this notice of privacy practices. Any violation will be grounds for disciplinary action. We reserve the right to change this policy in the future; such changes will be available to all patients.

Should you believe that your privacy rights have been violated, you may file a complaint with this facility or with the State oversight department; all complaints must be submitting in writing. You will not be penalized for filing a complaint.

Patient acknowledgment:

I acknowledge receipt of this information regarding my right to PHI privacy. I have also read the Disclosure Information given to me.

Dated: _____ Patient Name: _____

Charles A. Wallace, M.D.
Patient Consent Form: Use and Disclosure of Health Information Protected under HIPAA

Pursuant to the information contained in the Notice of Privacy Practices, I give permission for the use and disclosure of Protected Health Information (PHI) in order to carry out Treatment, Payment, and Healthcare Operations (TPO).

I am aware that I have the right to review the Notice of Privacy Practices prior to signing this consent. Should the Notice of Privacy be revised, I am aware that I may obtain a copy of the revised form by contacting the Medical Director of the facility.

I give my consent for this organization to contact me by calling my home or other designated location in order to leave a message (mechanically or with another person) or to speak to me directly regarding any matter which will help with the conduct of Treatment, Payment, and Healthcare Operations.

Further, I give my consent for the use of mail or e-mail to designated locations, including my home, to assist the organization in carrying out the described activities of Treatment, Payment, and Healthcare Operations.

I hereby consent to the use and disclosure of my PHI for the purpose of Treatment, Payment, and Healthcare Operations (TPO). This consent is good until revoked in writing, except to the extent that disclosures have been made in reliance upon my prior consent.

Services are provided without regard to sex, race, color, religion, national origin, or disability.

Dated: _____ Patient Name: _____

Patient Signature: _____

If applicable, Legal Guardian: _____

Copy: patient, patient's medical record