Please FILL, Print and Bring it to your appointment, OR Fax the filled form to us at 610-910-3899

PATIENT PRIVACY FORM

PATIENT INFORMATION

Last Name ______ **MI** ___ **First Name** ______ **SS #** ______ **Date of Birth** ______

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.
Regional Lung and Sleep Clinic is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

DISCLOSURE OF YOUR HEALTH CARE INFORMATION

TREATMENT
We may disclose your health care information to other health care professionals within our practice for the purpose of treatment, payment or health care operations.

PAYMENT
We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

WORKERS' COMPENSATION
We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

EMERGENCIES
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

PUBLIC HEALTH
As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

JUDICIAL AND ADMINISTRATIVE PROCEEDINGS
We may disclose your health information in the course of any administrative or judicial proceeding.

LAW ENFORCEMENT
We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

DECEASED PERSONS
We may disclose your health information to coroners or medical examiners.

ORGAN DONATION
We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

RESEARCH
We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

PUBLIC SAFETY
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

SPECIALIZED GOVERNMENT AGENCIES
We may disclose your health information for military, national security, prisoner and government benefits purposes.

Last Name ______ First Name ______ Date ______ ______________________
Patient Signature

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MARKETING

We may contact you for marketing purposes or fund raising purposes.

CHANGE OF OWNERSHIP

In the event that Regional Lung and Sleep Clinic is sold or merged with another organization, your health information/record will become the property of the new owner.

YOUR HEALTH INFORMATION RIGHTS

You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Regional Lung and Sleep Clinic is not required to agree to the restriction that you requested.

You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

You have the right to inspect and copy your health information.

You have a right to request that Regional Lung and Sleep Clinic amend your protected health information. Please be advised, however, that Regional Lung and Sleep Clinic is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s)and information about how you can disagree with the denial.

You have a right to receive an accounting of disclosures of your protected health information made by Regional Lung and Sleep Clinic

You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

CHANGES TO THIS NOTICE OF PRIVACY PRACTICES

Regional Lung and Sleep Clinic reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Regional Lung and Sleep Clinic is required by law to comply with this Notice.

Regional Lung and Sleep Clinic is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: Regional Lung and Sleep Clinic by calling this office at ~~610-910-3325~~ XXXXXXX If Regional Lung and Sleep Clinic is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

REGIONAL LUNG AND SLEEP CLINIC

New Phone #: 610-966-9667, New Fax#: 610-966-9660

COMPLAINTS

Complaints about your Privacy rights, or how Regional Lung and Sleep Clinic here has handled your health information should be directed to Regional Lung and Sleep Clinic by calling this office at ~~610-910-3325~~ XXXXXXX If your company name here is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of today's date listed below.

I have read the Privacy Notice and understand my rights contained in the notice. By way of my signature, I provide Regional Lung and Sleep Clinic with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

Last Name ________ First Name ________ Date ________ ____________________

Patient Signature

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