SALEEBY AND WESSELS PROCTOLOGY NOTICE OF PRIVACY PRACTICES AND AUTHORIZATION OF RELEASE OF INFORMATION

Patient Name____ **Date of Birth**______________________

This form describes how we may use and disclose your **Protected Health Information (PHI)** and how you can access this information. This notice is effective 4/13/2003. The HIPAA Privacy Notice has been provided in the office, as well as online at our website. Please review this form carefully and ask any questions if you do not understand something.

Your **PHI** is information about you that may identify you such as demographic information, past, present, and future physical and mental ailments or conditions, lab and other test results and medical and surgical services.

We may use and disclose your PHI for the purposes of **treatment** (plan, provide and coordinate your care including but not limited to other physicians, health care providers and health facilities), **payment** (including but not limited to health insurance companies, health facilities and billing services), **health care operations** (including but not limited to quality assessment, audits, statistics, training, licensing, transcription services, appointment reminders and contacting you), and other activities permitted or required by law.

We may disclose your PHI when it is deemed in your **best interest** by your physician including but not limited to family members or persons responsible for your care, to facilitate communication when necessary, and in an emergency situation.

We may disclose your PHI to any entity designated by you with your **written authorization**.

We may disclose your PHI **without** your consent or authorization when required by law, law enforcement authorities, a court, public health authorities, the Food and Drug Administration, when involving people exposed or at risk of contracting or spreading communicable or infectious diseases, and in cases of child or domestic abuse or neglect.

You have the following rights regarding your PHI:

- Request in writing, to inspect and copy your PHI.
- Request in writing, restriction on use and disclosure of your PHI. (but we are not required by law to agree to the restriction)
- Request in writing, to amend your PHI.
- Revoke this consent in writing at any time.(except to the extent that we have already taken action in reliance of this consent)
- Request a paper copy of this notice.
- You may complain to our privacy officer or the U.S. Dept. of Health and Human Services in writing if you believe your privacy rights have been violated. We will comply with Federal, State and Local laws on confidentiality of medical information.

Information that is disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

We reserve the right to change the privacy practices that are described above. You have the right to obtain a copy of the revised privacy practices.

I authorize Saleeby and Wessels Proctology to release my PHI to the named persons or organizations listed below: (check appropriate boxes and complete)

☐ **Spouse** ____
Print Name

☐ **Parent(s)** ____
Print Name(s)

☐ **Children** ____
Print Name(s)

☐ **Other** ____
Print Name(s) and Relationship to the Patient

I acknowledge that I have been provided with the Saleeby and Wessels Proctology Privacy Notification. I understand this form as well as my rights under the law as described above. I agree to consent to allow Saleeby and Wessels Proctology to use or disclose my PHI for the purposes described above.

____ ______________________
Signature of Patient **Date**

____ ______________________
Signature of Guardian or Representative **Relation to Patient** **Date**