Submit by Email Print Form

NOTICE OF PRIVACY PRACTICES

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

The federal government passed a new law in August 1996 dealing with the privacy of patient records. The new law is called Health Insurance Portability and Accountability Act. HIPAA for short. This is our general consent form. Again review it carefully.

Health Information Uses and Disclosures
In our medical practice, we routinely record, use and disclose your health information in order to treat and to assist other healthcare providers in treating you. We also use and disclose your healthcare information in order to obtain payment for our services.

Permitted Uses and Disclosures Without Your Consent or Authorization
We may need to disclose your health information without your authorization in the following situations:

- To contact you by telephone or mail to remind you of appointments or to respond to your questions.
- To family members or close friends who are involved in your healthcare.
- If we are providing healthcare services to you in an emergency.
- If there are substantial barriers in communicating with you, but in our professional judgment we believe that you intend for us to provide care.
- For purposes of public health and safety, such as to the FDA to report defects or incidents.
- To Government agencies for the purposes of their audits, investigations, and other oversight activities.
- For research purposes of a limited nature in a limited manner.
- For providing benefits under Worker's Compensation.
- To the law enforcement authorities to assist and or apprehend criminal offenders.
- To Government agencies for prevention of child abuse and domestic violence.
- When required by law, search warrants, subpoenas, or court orders.

Our Privacy Pledge
We have and always will respect your privacy. We will not use or disclose your health information without your prior written authorization, other than the uses and disclosures we describe above.

Your Right To Revoke Your Authorization
You may revoke your authorization to us at any time; however, your revocation must be in writing. There are two circumstances under which we will not be able to honor your revocation request:

1. If we have already released your health information before we received your request to revoke your authorization.

2. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information. If they decide to contest any of your claims, your revocation authorization must be submitted to our office in writing.

Your Right to Limit Uses or Disclosures
If there are healthcare providers, hospitals, employers, or other individuals or organizations to which you do not want to disclose your information, it must be submitted in writing.

Your Patient Rights
As a patient, you have the following rights:

- To receive a copy of the Notice of Privacy Practices.
- To obtain access to and/or a copy of your health information.
- To request that we communicate with you confidentially by reasonable alternative means.
- To request how we handle or disclose your health information.
- To request amendments to your health information.
- To request an accounting of certain disclosures which we have made of your health information.

Should you have any questions, concerns, or complaints regarding our Privacy Practices, now or in the future, you may contact our Privacy Official, Alex Kalnitsky. She can be reached at (561) 638-1078.

You also have the right to submit a written complaint to:

The U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue SW
Washington, DC 20201

I acknowledge that I was provided a copy of the Notice of Privacy Practices from the Med Diagnostic Rehab of South Florida for me to keep and I have had an opportunity to read and understand the notice. This acknowledgement is requested per Government Statute.

_____	_____
Patient Name (Please Print)	Parent or authorized representative
_____	_____
Signature	Date