

PRIVACY POLICY

It has ALWAYS been the policy of **Anderson Cosmetic and Vein Institute** to strictly protect the privacy of all of our patients. Recently, the federal government has agreed with us. As such, they have mandated (through HIPAA) that all medical practices in the United States implement a formal privacy policy, which must be made available to patients. What follows is our privacy policy. Please sign at the bottom of the second page to indicate that you have read it.

How we may use and disclose your medical information:

- ❖ **For your Treatment:** We may use your health information to provide you with medical treatment or services. People outside of the office may need your information, such as family members, laboratories, physicians, or others that may be involved with your care.
- ❖ **For Health Care Operations:** We may use and disclose medical information about you for office operations. These uses and disclosures are necessary to run the office and make sure that all of our patients receive quality care.
- ❖ **Individuals Involved with your Care or Payment for your Care:** We may release medical information about you to a friend, physician or family member who is involved with your medical care or who helps pay for your care.
- ❖ **As Required by Law:** We may disclose your medical information when required to do so by federal, state or local law.
- ❖ **As a Result of your Waiving Your Rights to Confidentiality**
- ❖ **Public Health Risks:** Your medical information may be disclosed for public health activities such as to report reactions to medications or problems with products.

Your Rights Regarding your Medical Information

- ❖ **Right to Inspect and Copy:** You have the right to request access to, inspect, and copy your medical information. To inspect and copy medical information, you must submit your request in writing. If you request a copy we may charge a fee for the costs of copying, Mailing or other supplies related to your request.
- ❖ **Right to Amend:** You have the right to ask us to amend or change any information you feel is incorrect or incomplete. An amendment request must be made in writing, including the reason you are requesting the amendment. You may be denied if it is not in writing or does not include a reason for the request.
- ❖ **Right to an Accounting of Disclosures:** You have the right to an “accounting of disclosures of.” This is a list of the disclosure we have made of your medical information for reasons other than what was stated above.
- ❖ **Right to Request Restrictions:** You have a right to request a restriction or limitation on your medical information. This includes the amount of information we provide to a friend, family member or one involved with your care or payment of treatment. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you

emergency care. To request restrictions, the request must be in writing and include: what information you want to limit, whether you want to limit our use, disclosures or both and to whom you want the limits to apply.

- ❖ **Right to Request Confidential Communications:** You also have the right to request that we communicate with you about your medical matters in a certain way. For example, you may request us to contact you only at work and not at home.
- ❖ **Right to a Paper Copy of this Notice:** You have the right to a paper copy of this notice. You may request a copy at any time.

Changes to this Notice

We reserve the right to change this notice, effective for medical information we already have about you as well as any information we receive in the future.

Complaints

If you believe your privacy rights have been violated, you are encouraged to file a complaint with our office manager or with the Secretary of the Department of Health and Human Services.

Other Uses of Medical Information

If at any time, your medical or billing information has been requested by outside entities or you wish to disclose your information to outside entities, such as new physicians, research organizations, etc., a separate specific authorization will need to be completed. Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written consent. If you provide us permission to use or disclose medical information, you may revoke that permission at any time, in writing. If you revoke your permission we will no longer use or disclose your medical information for the reason covered in your request. You understand we cannot take back any disclosure we have already made with your permission and that we are required to retain our records of the care that we provided to you.

Questions and Requests

If you have any questions about our privacy policy or this notice, or if you wish to make written requests, contact Jeni at 7794 Five Mile Road, Suite 270, Cincinnati, OH 45230 or by phone (513) 624-7900.

Please sign below to indicate that you have received a copy of our privacy policy.

Signature

Date