

## HIPAA 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**

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, health care operations and for other purposes that are permitted or required by law. It also describes your right to access and control your protected health information. "Protected health information": is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

### **Uses and Disclosures of Protected Health Information**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing healthcare services to you, to pay your health care bills, to support the operation of the physician's practice and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you, or your protected health information may be provided to a physician to whom you have been referred or seek counsel from, to ensure that physician has the necessary information to diagnosis or treat you.

Treatment and office visits in our facility will require that you be called by name in the reception area. You will be asked personal and medical history questions by medical personnel to ensure safe and appropriate care in our surgery center. You may share a pre- or post-op area with other patients in the surgery center.

Obtaining approval or scheduling procedures or a hospital stay may require that your relevant protected health information be disclosed to the health plan or medical facility.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services.

**Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, medical studies, and conducting or arranging for other business activities. You may be greeted by name at our reception desk and asked to complete registration forms or sign consent for procedures. We may also call you by name in the reception area when your physician is ready to see you. We may use or disclosure your protected health information, as necessary, to contact you to remind you of your appointment or inform you of test results. We may contact you by telephone, email, postal service or other forms of delivery services as your doctor deems necessary.

We may use or disclose your protect health information in the following situations without your authorization. These situations include: As Required by Law, Public Health Issue As Required by Law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' compensation, Inmates, Required Uses and Disclosures. Under the law we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirement of Section 164.500 of the Federal Code of Regulations.

Telephone calls to Swan Gastroenterology may be monitored or recorded randomly by management for quality assurance or training purposes only. Swan Gastroenterology may utilize SMS messaging for notification purposes only. You may opt out of this option at any time by contacting our office.

**\*Research:** We conduct clinical research involving investigational medications and devices in the treatment of various conditions. This may be offered to patients by the physicians, practitioners or their research representatives, Del Sol Research Management, LLC, as an option in the course of treatment. Decisions for or against involvement in clinical research will not alter the patient relationship.

Your protected health information may be used or disclosed for research purposes to the extent such use or disclosure has been approved by an Institutional Review Board that has reviewed applicable research proposal and protocols to address the privacy of your protected health information or in limited circumstances where the use or disclosure is merely preparatory to conducting a research project or to determine if you may be a candidate for a research project so that you may be offered this research option. You will be given specific information about research projects for which you a candidate or in which you are asked to participate.

Other permitted uses and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

**Your Rights Regarding Your Health Information**

**You have the right to inspect and copy our protected health information:** You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes or information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. You must submit your request for medical records in writing to your doctor.

**You have the right to request a restriction of your protect health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request, in writing, must state the specific restriction requested and to whom you want the restriction to apply. *(Please ask the receptionist for a form.)*

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.

You also have the right to request, in writing, to receive confidential communication from us by alternative means or at an alternative location.

**You may have the right to ask your physician to amend your protected information.** If you believe your medical record is incorrect or incomplete, you may amend your record using an authorized amendment form. The original form must be placed in your medical file at this practice. You may request an amendment form from this office. Your request must be made in writing and submitted to your doctor at Swan Gastroenterology, 1505 N. Swan Rd, Tucson, AZ 85712. The original information will also be retained in your file.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice. You then have the right to object or withdraw as provided by this notice.

**Right to File a Complaint.** If you believe your privacy right have been violated, you may file a complaint with us by notifying our HIPAA Compliance Officer. We will not retaliate against you for filing a complaint.

**You may revoke this authorization at any time,** in writing, except to the extent that your physician or physician’s practice has taken an action in reliance on the use or disclosure indicated in the authorization.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. You may ask our office for a copy of this Notice at any time. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at (520) 795-3090.

**Signature below is only acknowledgement that you received this HIPAA Notice of Privacy Practices**

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

**\*Do you consent to having your protected health information disclosed for Research?**

**Check here:**

YES

NO

\_\_\_\_\_  
**(Initial Here)**