Foundations Medical Center

NOTICE OF PRIVACY PRACTICES

4467 Commons Dr. Ste F-G

Destin, FL 32541

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

It is our policy to maintain the privacy of your health information. This notice explains our privacy practices, our legal duties, and your rights concerning your health information. We will follow this Notice while it is effect, beginning Jan 16, 2015, and until we replace it. If we change this Notice and our privacy practices, we may make the changes effective for all health information that we maintain, including health information we created or received before we made the change. You may request a copy of this or future versions of this Notice by contacting Foundations Medical Center Manager or Clinic Coordinator.

ACKNOWLEDGEMENT OF RECEIPT

We will ask you to sign an acknowledgement that you received this notice. However, your care will not depend on signing the acknowledgment and we will continue to provide your treatment and will use and disclose your information as necessary within the provisions of this Notice.

YOUR RIGHTS

Access: You have the right to look or get copies of your health information, with limited exceptions such as certain mental health information. Requests must be in writing and signed by you. You may request a form for this purpose from the office.

Release of Health Information: You make request that we provide copies of you r health information to others. To do so, submit a signed, written request authorizing us to do so. You may revoke your authorization in writing at any time.

Correction: You may ask Foundations Medical Center to correct health information we have created if the information is wrong or incomplete. Correction requests must be submitted in writing with an explanation of why you want the information changed.

Accounting Disclosures: You have the right to know with whom Foundations Medical Center has shared your health information. Requests must be submitted in writing and include your signature.

Request Restrictions: You may ask us not to share your health information with certain individuals for certain purposes, including family members who may be involved in your care. To ask for a restriction, send your request in writing and clearly state with whom you want us to restrict your information and to what extent. Please note, that we are not required to comply with your request if we believe it necessary to share your information.

Confidential Communications: You may specify where and how our staff may contact you, such as only at work or by mail. Submit your request in writing, stating how or where you wish to be contacted.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and may disclose to others health information about you for the following purposes:

Treatment: We may use or disclose your health information to a physician or other healthcare professional who is providing treatment to you.

Appointment Reminders: We will use information about you to remind you of an upcoming appointment via telephone or mail.

Family/Responsible Party: We may share information about you with a family member who you have said who is responsible for your care. You have the right to stop or limit the disclosure of information in this way.

Healthcare Operations and Oversight: We may use your information to help assess and/or improve the quality of our services, such as reviewing the competence or qualifications of healthcare professionals and evaluating clinician and treatment performance.

Treatment Alternatives and Health Related Benefits Services: We may disclose your information to explore and recommend possible treatment options, benefits and services that may exist for you.

As Required by Law: We will share your health information when the law requires us to do so. Applicable circumstances include but are not limited to reporting public health threats such as infectious diseases, reporting suspected abuse, violence or neglect victims, complying with subpoena, summons, and other lawful procedures, and providing information needed for a correctional or other custodial residential entity to provide health care to you or to protect the health and safety of others.

Questions and Complaints: If you believe your privacy rights have not been maintained while receiving our services, you may file complaint with Foundations Medical Center at the address shown on page 1 or with the U.S. Department of Health and Human Services. All complaints must be in writing. You will not be penalized for filing a complaint.

Medical Information Release Form (HIPAA Release Form)

( ) I authorize the release of information including the diagnosis, records: examination rendered to me and claims information. This information may be released to:

( ) Spouse:_____

( ) Child(ren):_____

( ) Other: _____

( ) Information is NOT to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Acknowledgment of Receipt:

My signature below acknowledges that this 2-page notice has been given to me to review and that I have been offered and received a copy if I so desire.

Signature_____ Date_____

Name Printed_____