REGAL PARK
MEDICAL CENTER

8214 Milwaukee Ave • Lubbock TX 79424-0923 • Phone: (806)-795-6421 • Fax: (806)-795-1528

HIPAA NOTICE OF PRIVACY PRACTICES

Date: _____

Name: _____ **DOB:** _____

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, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information (PHI) includes 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.

I. 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 health care 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.

a. 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. As another example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

b. Payment

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

c. 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, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you, as well as use or disclose your protected health information, as necessary, to contact you in order to remind you of your next appointment.

We may use or disclose your protected health information in the following situations without your authorization: anything qualified as required by law, including public health issues 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; national security; workers' compensation; inmates; and required uses and disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

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

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

II. Your Rights

The following is a statement of your rights with respect to your protected health information:

a. You have the right to inspect and copy your protected health information.

However, under federal law, you may not inspect or copy the following records: psychotherapy notes, 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.

b. You have the right to request a restriction of your protected health information.

This means you may ask us to not 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 for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

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 health information will not be restricted. If you wish to not permit such action, you then have the right to change to a difference healthcare professional.

c. You have the right to request to receive confidential communication from us by alternative means or at an alternative location.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively (such as electronically).

d. You may have the right to have your physician amend your protected health information.

If we deny your request for amendment, you have the right to file a statement of disagreement with us. In addition, we have the right to prepare a rebuttal to said statement and will provide you with a copy of any such referral.

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

WE SERVE THE RIGHT TO CHANGE THE TERMS OF THIS NOTICE AT ANY TIME AND WILL INFORM YOU BY MAIL OF ANY CHANGES. YOU THEN HAVE THE RIGHT TO OBJECT OR WITHDRAW AS PROVIDED IN THIS NOTICE.

Complaints:

You may file a complaint to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint, and we will not retaliate against you if you do choose to file a complaint.

This notice was published and becomes effective on or before January 1st, 2020.

REGAL PARK MEDICAL CENTER
8214 MILWAUKEE AVE
LUBBOCK, TX 79424-0923

We are required by law to maintain the privacy of individuals as well as provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at (806)-795-6421.

Signature below is acknowledgement that you have read and agreed to this Notice of Privacy Practices:

Patient Printed Name: _____ **Date:** _____

Patient Signature: _____ **Date:** _____

or

Responsible Party Signature: _____ **Date:** _____

CONSENT TO THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, HEALTHCARE OPERATIONS, AND AS OTHERWISE ALLOWED BY LAW

Regal Park Medical Center will maintain a record of the care and services you receive at Regal Park Medical Center. This consent only covers your protected health information created while you are a patient of Regal Park Medical Center, including, but not limited to: information concerning mental illness (except for psychology notes); use of alcohol or drugs; communicable diseases such as Human Immunodeficiency Virus (HIV) and/or Acquired Immune Deficiency Syndrome (AIDS); laboratory results; medical history; treatment progress; or any other related information.

By signing this form, you consent to Regal Park Medical Center's use and/or disclosures of protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. Our Notice of Protected Health Information Practices provides information about how Regal Park Medical Center and its physicians may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law.**By signing this form, you also acknowledge that you have received a copy of Regal Park Medical Center's Notice of Protected Health Information Practices and an opportunity to review it before signing this consent.**

Patient Signature: _____ **Date:** _____

or

Responsible Party Signature: _____ **Date:** _____

HIPAA AUTHORIZATION

I authorize the following person(s) to discuss my medical care and billing/insurance information with the staff of Regal Park Medical Center on my behalf:

Name of Authorized Person: _____

Relationship to Patient: _____ **Date:** _____

Name of Authorized Person: _____

Relationship to Patient: _____ **Date:** _____