

NOTICE OF PRIVACY PRACTICES

Space Coast Endoscopy Center - 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.

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| Patient Health Information | <p><u>Judicial and administrative proceedings:</u> We may disclose information in response to an appropriate subpoena, discovery request or court order.</p> | <p>remind you of appointments.</p> <p><input type="checkbox"/> In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for copies.</p> <p><input type="checkbox"/> You have the right to request that we amend your information.</p> <p><input type="checkbox"/> You may request a list of disclosures of information about you for reasons other than treatment, payment, or health care operations and except for other exceptions.</p> <p><input type="checkbox"/> You have the right to obtain a paper copy of the current version of this Notice upon request, even if you have previously agreed to receive it electronically.</p> |
| How We Use & Disclose Your Patient Health Information | <p><u>Treatment:</u> We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.</p> | <p><u>Deaths:</u> We may disclose information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.</p> <p><u>Serious threat to health or safety:</u> We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.</p> |
| | <p><u>Military and Special Government Functions:</u> If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.</p> | <p><u>Workers Compensation:</u> We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness.</p> |
| | <p><u>Business Associates:</u> We may disclose your health information to business associates (individuals or entities that perform functions on our behalf) provided they agree to safeguard the information.</p> | <p><u>Messages:</u> We may contact you to provide appointment reminders or for billing or collections and may leave messages on your answering machine, voice mail or through other methods.</p> |
| | <p>In any other situation, we will ask for your written authorization before using or disclosing identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures. Subject to compliance with limited exceptions, we will not use or disclose psychotherapy notes, use or disclose your health information for marketing purposes or sell your health information, unless you have signed an authorization.</p> | <p>Complaints If you are concerned that we have violated your privacy rights, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.</p> |
| | <p>Individual Rights</p> | <p>Contact Person If you have any questions, requests, or complaints, please contact:</p> |
| | <p><u>Required by Law:</u> We may be required by law to disclose your information, such as to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.</p> | <p>Center Director, Lynn Drake 321-504-4440</p> |
| | <p><u>Research:</u> We may use or disclose information for approved medical research.</p> | <p>I hereby acknowledge receipt of the Notice of Privacy Practices given to me.</p> |
| | <p><u>Public Health Activities:</u> We may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.</p> | <p>Signed: _____ Date: _____</p> |
| | <p><u>Health oversight:</u> We may disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.</p> | <p>If not signed, reason why acknowledgement was not obtained: _____</p> |