MISSION EAST DALLAS
FAMILY HEALTH CLINIC

NOTICE OF PRIVACY PRACTICES

The privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA) require that medical groups provide patients with a notice that describes how protected health information may be used and disclosed, and that explains patients' rights and the medical group's duties.
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment: We are permitted to use your health care information as necessary to provide you with medical treatment and services. We may disclose information about you to physicians, nurses, technicians, medical students or others who are involved in taking care of you.

Payment: We are permitted to use and disclose your health care information in order to bill and receive payment from you, or your insurance company for the services you receive from us. As an example, we will share information about your office visit with your insurance company so that they will reimburse us for the care you received. We will also share information with your insurance company about your condition and the treatment you are going to receive in order to determine if it will be pre-approved for payment by your insurance company.

Health Care Operations: We are permitted to use your health care information for our business operations. Our physicians may use your information to determine the quality of care you have received, and whether any improvements are needed in our systems. We may also disclose your information to another health care provider or health plan if they have a relationship with you and require the information for their own business operations.

Our practice is permitted or required to use or disclose confidential information without your written authorization in the following cases:

a) Uses and disclosures for public health activities; such as reporting disease, injury and vital events such as births and deaths, reporting about adult victims of abuse, neglect or domestic violence regardless of the circumstances, reporting about child victims of abuse or neglect if the suspected actions relate directly their medical care and reporting reactions to medications and problem products.

b) Disclosures for health oversight activities for activities authorized by law including audits, investigations, inspections and licensure.

c) Disclosures for judicial and administrative proceedings where required by the court or an administrative order if you are involved in a lawsuit or a dispute.

d) Disclosures for law enforcement purposes where required by court order, warrant, criminal subpoena or other lawful purposes.

e) Uses and disclosures about decedents where required by state and federal law.

f) Uses and disclosures for cadaveric organ, eye or tissue donation purposes, where required by law, or your personal preferences that you have recorded in your chart.

g) Disclosures to avert a serious threat to health or safety, where required by state or federal regulations.

h) Uses and disclosures for specialized government functions, including monitoring US health care system, government programs and compliance with civil rights laws.
Other uses and disclosures will be made only with your written authorization and that you may revoke such authorization at any time.

Separate Statements for Certain Uses

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The practice may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. The practice may contact you to request your participation in marketing or fundraising activities for the practice.

Individual Rights As a part of the new regulations, you have several individual rights with respect to protected health information:

1. You have the right to request restrictions on certain uses and disclosures, although the practice is not required to agree to a requested restriction;

2. You have the right to receive confidential communications;

3. You have the right to inspect and copy protected health information, provided your physician has not deemed that inspection to be a danger to your health or the health of others;

4. You have the right to request that we amend protected health information, should you find it to be incomplete or in error;

5. You have the right to receive an accounting of disclosures of protected health information; and

6. You have the right to obtain a paper copy of this notice from the practice upon request, even if you have previously agreed to receive this notice electronically.

Medical Practice's Duties

1. Our practice is required by law to maintain the privacy of confidential information and to provide individuals with notice of its legal duties and privacy practices with respect to such information;

2. Our practice is required to abide by the terms of the notice currently in effect; and

3. Our practice reserves the right to change the terms of this notice and to make the new notice provisions effective for all confidential information that we maintain. Should we decide to change the terms of our notice, we will send the revised notice to you either in electronic format, or via paper, depending upon your previously stated preference.

Complaints
If you believe that your privacy rights have been violated, you may file a complaint with the practice (see contact information below) and/or to the US DHHS Office for Civil Rights by using the following methods:
Mail: Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F HHH Bldg.
Washington, D.C. 20201

E-mail: OCRComplaint@hhs.gov
Online: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf

Please note that we will not retaliate against you in any way for filing complaints.
Should you have any questions or complaints, please direct them by mail to:
Charles Wiltraut, Chief Executive Officer
4550 Gus Thomasson, Suite 40
Mesquite, TX 75150
Or by phone at 972-682-8917

Acknowledgment of Notice of Privacy Practices

Updated 9.12.2018 CP

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These regulations require us to make a good faith effort to obtain your written acknowledgment of receipt of the notice of privacy practices, so we request that you read the above and sign the following:

I acknowledge receipt of Mission East Dallas Family Health Clinic Notice of Privacy Practices. I also acknowledge I have been given or offered a copy of my signed authorization.

_____ _____

Patient's Signature **Date**

_____

Patient's Name (please print)