

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 is being provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). This Notice describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your right to access and control your health information in some cases. Your "protected health information" means any of your written and oral health information, including demographic data, which can be used to identify you. This is health information that is created or received by your health care provider, and relates to your past, present, or future physical or mental health or condition. This information may be stored in either a paper or electronic format, or both.

Uses and Disclosures of Protected Health Information (PHI) Your PHI may be used or disclosed by your physician or other primary care provider (collectively referred to as "provider"), our office staff and others outside of 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 provider's practice, and any other use required by law. **Treatment:** We will use and disclose your PHI 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 PHI, as necessary, to a home health agency that provides care to you. For example, your PHI 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. **Payment:** Your PHI 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 PHI be disclosed to the health plan to obtain approval for the hospital admission. **Health Care Operation:** We may use or disclose, as needed, your PHI in order to support the business activities of your provider'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 PHI 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 may be asked to sign your name and indicate your provider. We may also call you by name in the waiting room when your provider is ready to see you. We may use or disclose your PHI, as necessary, to contact you

to remind you of an appointment. We may use or disclose your PHI in the following situations without your authorization. These situations include: As required by law; Public health issues required by law, including communicable diseases; Health Oversight; Abuse or neglect; Food or Drug Administration requirements; Legal proceedings; To law enforcement; To Coroners, Funeral Directors and Organ Donation Programs; Research; Criminal Activity; Military Activity and National Security; Worker's Compensation; For inmates. Other permitted and required uses and disclosures will be made upon receipt of your consent or authorization. You may revoke this authorization at any time, in writing, except to the extent that your provider or the provider's practice has taken action in reliance on the user or disclosure indicated in the authorization. Under the law, we must make disclosures to you upon request and when requested by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements.

Your Rights Following is a statement of you rights with respect to your protected health information (PHI). You have the right to inspect and request copies of your PHI. Under federal law, however, 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 PHI that is subject to law that prohibits access to such PHI. To receive a copy of your records, a written authorization must be completed. You may request to receive in an electronic format any of your records that are stored and readily producible in an electronic format. You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or health care operations. You may restrict the disclosure of your PHI to your health plan if services are paid for in full. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction and to whom you want the restriction applied. With exception of the aforementioned restriction to your health plan, your provider is not required to agree to a restriction that you may request. If the provider believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to choose another health care provider. **You have the right to request to receive confidential communications 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, i.e. electronically. **You have the right to request to have your provider amend your PHI.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare rebuttal to your statement and will provide you with a copy of any such rebuttal. **You have the right to receive an accounting of certain disclosure we have made**, if any, of your PHI. **You will receive notification in the event**

of a breach that affects your unsecured PHI. You have the right to complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may email at info@afiyahmedical.org a complaint if you suspect that your privacy rights have been violated. **We will not retaliate against you for filing a complaint.** You may also file a complaint with the Secretary of the Department of Health and Human Services. You may speak with the Office Manager to obtain additional information regarding any questions you may have concerning this Notice or to receive a printed copy of the Notice. This Notice of Privacy Practices is effective as of December 15, 2021.

By signing below you are confirming, that you have been given the opportunity to review, understand and consent to **Al Afiyah Medical Care** practice of Privacy Practice as written.

Patient Signature: _____ Date: _____

Print Patient Name: _____ DOB: _____