

## Malhotra Center for Plastic Surgery, PC

### HIPPA notice of privacy practices Effective date: August 8, 2010

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. If you any questions contact the office manager at the Malhotra Center for Plastic Surgery, PC 900 E. Michigan Avenue, Jackson, MI. 49201 Phone: 517-789-9800 or 2300 Washtenaw Suite 100, Ann Arbor 48104 734 913-5100.

Your medical information is personal. We are committed to protecting your medical information. We create a record of the care and services received at this office. We need this record to comply with certain legal requirements. This noticed applies to all of the records of your care generated by this office, whether made by your physician or office employee.

This notice will tell you about the ways in which we may use and disclose your medical information. This notice will also describe your rights and certain obligations we have regarding the use and disclosure of your medical information.

This office is required by law to:

1. Make sure that medical information that identifies you is kept private;
2. Give you this notice of our legal duties and privacy practices with respect to medical information about you ; and
3. Follow the terms of the notice that is currently in effect.

#### **How this office May Use and Disclose Your Medical Information:**

The following describes the different ways that your medical information may be used or disclosed by this office. For clarification we have included some examples. Not every possible use or disclosure is specifically mentioned.

1. Treatment: Means providing, coordinating, or managing healthcare related services by one or more healthcare providers. An example of this would include a physical examination.
2. Payment: Means such activities obtaining reimbursement for services, confirming coverage, billing our collection, activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
3. Healthcare operations: Include the business aspects of running our practice to make sure that all of our patients receive quality care.
4. We may also use or disclose your medical information for appointment reminders, to recommend treatment alternatives, to explain health related benefits or services, for research purposes, as required by law for federal, state, and local purposes, to avert a serious threat to health, your safety, to governmental or health oversight agencies, for lawsuits or disputes, and for law enforcement purposes.
5. We may also create and distribute. The identified health information by removing all references to individually identifiable information.
6. Any other disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions or are relying on your authorization.

#### **Your rights regarding your medical information.**

You have the following rights with respect to your protected health information:

1. The right to inspect and copy your protected health information.
2. The right to amend your protected health information.
3. The right to receive an accounting of disclosures of protected health information.
4. The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at an alternative location.
5. The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
6. The right to obtain a paper copy of this notice from us upon request.

We reserve the right to revise this notice. Any revised notice will be effective for medical information we already have about you as well as any information received in the future. We will offer you a copy of any revised notice.

#### **Complaints**

If you believe your privacy rights have been violated, you may file a complaint with this office, by contacting the office manager, or with **the secretary of the department of Health and Human Services. This must be done in writing and there will be no penalty to you in any way for filing a complaint.**

Other uses of medical information that are covered by this notice of privacy practices, will be made only with your written authorization. You make revoke such authorization in writing at any time. If you revoke your authorization we will no longer use or disclose medical information about you.

By signing below acknowledge that I received a copy of this notice of privacy practices to view and may request a copy to take with home.

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Patient signature

date

*office employees only: I attempted to obtain the patient signature and acknowledgment of this notice of privacy practices, but was unable to do so as documented below:*

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*Date*

*initials*

*reason*