Notice of Privacy Practices

The Heart and Vascular Specialists

Shashi S. Bellur M.D., P.A., F.A.C.C.
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This notice describes how medical information about you may be used and disclosed and how you can access this information.

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The Health Insurance Portability and Accountability Act of 1996 (HIPPA) is a federal program that requires that all medical records and other individually identifiable information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information.

As required by HIPPA, we have prepared this explanation of how we maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and healthcare operations

- **Treatment** means providing, coordinating, or managing healthcare and related services by one or more healthcare providers. An example of this would include teeth cleaning services.
- **Payment** means activities obtaining reimbursement for services, conforming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your insurance company for payment.
- **Healthcare Operations** include the business aspect of running our practice such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example of this would be an internal quality assessment review.

We may also create and distribute identified health information by removing all references to individually identifiable information.

We 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.

Any other uses and 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 may have already taken actions relying on your authorization.

You may have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the privacy officer.

- The right to request restrictions on certain uses and disclosures of protected health information.
- The right to reasonable request to receive confidential communication of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to receive a copy of this notice from us upon your request.

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Acknowledgement of Review

I have reviewed the Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this notice if requested.

Patient Name ______________________ Patient Signature ______________________

If completed by a patient's personal representative, please print and sign your name.

Personal Representative ______________________ Personal Representative Signature ______________________

Authorization for Release of Medical Information

☐ I authorize The Heart and Vascular Specialists and its representatives to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my appointments, billing information and/or medical care. This authorization will remain in effect until I provide written notification to The Heart and Vascular Specialists of changes or update.

Name______________________Relationship______________________

Phone______________________

You may release the following information to the person named above:

☐ Appointments ☐ Billing Information ☐ Medical Care ☐ Leave Message

Name______________________Relationship______________________

Phone ______________________

You may release the following information to the person named above:

☐ Appointments ☐ Billing Information ☐ Medical Care ☐ Leave Message

Signature______________________Date______________________