FLINT HILLS
FAMILY MEDICINE

## HIPAA PRIVACY NOTICE FOR FLINT HILLS FAMILY MEDICINE

**PATIENT NAME**_____

**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**

1. **Uses and Disclosures:** Flint Hills Family Medicine is permitted by law to disclose the minimum necessary personal health information of each patient to carry out treatment, payment and health care operations of the medical office. For treatment purposes, such disclosures may be made to physicians and other health care providers as necessary to effectuate the appropriate treatment and care of patients. Personal health information may be disclosed to the government or other third party payors for the purpose of obtaining payment for services provided. Flint Hills Family Medicine may also use personal health information to carry out the medical offices day to day operations such as scheduling, quality review and appointment reminders.
2. **Required Authorizations:** Flint Hills Family Medicine will not disclose any patient's personal health information for any purpose aside from payment, treatment and health care operations, without patient's authorized consent to such disclosure. Upon request for such authorization, patient shall have the right to refuse and/or revoke any disclosure of patient's personal health information.
3. **Privacy Compliance:** In accordance with the privacy regulations promulgated under the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164 (the "Privacy Regulations"), Flint Hills Family Medicine has adopted privacy policies regarding usage of patients' personal health information. Flint Hills Family Medicine is committed to compliance with the Privacy Regulations and all other laws and regulations regarding patients' right to privacy.
4. People listed as my emergency contacts may have my medical information.
5. I will authorize electronic exchange of information by opting in or out for the purpose of medical business for my behalf.
6. **Additional Information:** We will keep a copy of the current notice at Flint Hills Family Medicine. The notice will contain the effective date that you filled out this form.

**The following signature acknowledges that I have received notification of my privacy rights concerning the use and disclosure of protected health information as defined by the Privacy Regulations.**

**The following signature acknowledges that I have read and understand this Notice.**

_____ **Date** _____

**Signature**