

Arizona Vein & Vascular Center
Notice of Privacy Practices
HIPPA

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

We are required by law to maintain the privacy of your health facts and to provide you with the notice of our legal duties and privacy practices. We must follow the terms of the notice in effect as of this date, but we reserve the right to change the terms. If there is any changes in terms we will disclosed to you in writing the revised notice upon request.

As a patient of ours, facts about you must be used and disclosed to other parties for treatment, payment and healthcare procedures. These uses and disclosures require your consent, and include, but are not limited to the following information:

A release of information contained in financial and or medical records

Disease spread person to person, such as HIV, AIDS

Drug or alcohol abuse

Psychiatric diagnosis and treatment records

Laboratory testing and results

Medical History

Treatment progress

Data from the OASIS data set (home health)

Any other related facts.

We may release the above information to:

Your insurance company, Medicare, AHCCCS, or any other person who will pay your bills or process your bills for services in order for us to receive payment for such services

Any person from a program or an insurance company, who performs billing, quality and risk management tasks, such as insurance auditors ond state Risk Management Any hospital, nursing home, or other healthcare facility where you may have testing done or to which you may be admitted

Any assisted living or personal care facility where you live

Any doctor providing your care

Family members and other people who are part of your plan of service, in such programs as CSHP, EPSDT, home health, hospice, etc..

State and Federal agencies acting on behalf of these programs, Medicare or Medicaid, including state surveyors and Auditors for programs such as CSHP, EPSDT, PCSM, WIC, STD/HIV, home health, hospice, etc..

Other health care providers to start treatment.

We may contact you to:

Provide appointment reminders or news about other health programs we provide

We are allowed to use or disclose facts about you without consent in the following situations:

In emergency treatment situations, if we try to obtain consent as soon as possible after treatment

Where significant barriers to communicating with you exist and we determine that the consent is clearly inferred from the situation

Where we are required by law to provide treatment and we are unable to obtain a consent

Where the use or disclosure in required by law

For certain public health activities, such as reporting births, deaths, injuries, disease, etc..

Where we reasonably believe that you are victim of abuse, neglect, or domestic violence to a government agency authorized to receive such reports

Health care oversight activities

Certain legal administrative proceedings
Certain law enforcement purposes
To coroners, medical examiners and /or funeral directors in certain situations
For organ donation
Research purposes
To avoid a serious threat to health and safety
For specialized government functions, including military and veterans' activities, national security and intelligence activities, protective services for the President and others, correctional institution and custodial situations
Workman's Compensation

Other uses and disclosures will be made only with your written approval. That approval may be withdrawn in writing at any time, except in limited situations.

Your Rights

You have the right, subject to certain restrictions, to:
Request restrictions on certain issues and disclosures of facts about you by filling out our Request form. However we are not required to agree to these requests and/or restrictions.
Receive confidential communication to protect health data by giving us another address or means of receiving health data
Inspect or copy protected health information, by filling out a request form
Amend protected health data by filling out request form
Receive a list of disclosures made of your protected health data filling out our request form
Obtain a paper copy of this notice upon request if you agree to receive this notice by e-mail, fax, or website

COMPLAINTS

You may complain to us or the Secretary of the U.S. Department of Health and Human Services if you believe that your privacy rights have been violated. There will be no retaliation against you for filing a complaint. The complaint must be filed in writing with us and must specify incident(s) including date, what happened and details of the incident.

For details about filing a complaint with us, contact our office at
623-544-6932

ACKNOWLEDGEMENT

I have read this Notice and/or have had it explained to me. I understand this Notice and/or have had the chance to ask questions about any matters I do not understand.

Patient Signature: _____

Date Signed: _____