Woods Cardiovascular Internal Medicine Associates, P.C.

Summary of the HIPAA Privacy Rule*

*For a full, detailed copy of the HIPAA Privacy Rule, please request a copy from the front desk staff

HIPAA is a federal law that gives you rights over your health information and sets rules and limits on who can look at and receive your health information.

You have the right to:

- Ask to see and obtain a copy of your health records
- Have corrections added to your health information
- Receive a notice that tells you how your health information may be used and shared
- Decide if you want to give your permission before your health information can be used or shared for certain purposes, such as marketing

What information is protected?

- Information your healthcare providers put in your medical record
- Conversations your doctor has had about your treatment with other healthcare professionals
- Billing information about you from your healthcare provider
- Most other health information about you, held by those who must follow this law

Your information is kept private by:

- Teaching the people who work for us how your information may and may not be used or shared
- Taking appropriate and reasonable steps to keep your health information secure

To make sure that your information is protected in a way that does not interfere with your healthcare, your information can be used and shared:

- For your treatment and care coordination
- Teaching the people who work for us how your information may and may not be used or shared
- With your family, relatives, friends, or others you identify who are involved with your healthcare (only with your written permission)

Your health information cannot be used or shared without your written permission unless this law allows it. For example, without your authorization, your provider generally cannot give your information to your employer or use or share your information for marketing or advertising purposes.

By signing below I acknowledge that I have read and been offered a copy of this office's HIPAA Privacy form.

_____ _____

Patient or Personal Representative Signature Date

_____ _____

Witness Signature Date

If a Personal Representative's signature appears above, please describe the relationship to the patient:_____

FOR OFFICE USE ONLY

On _____, _____ presented this HIPAA Privacy form to

_____ (the "patient"). The Patient refused to provide a signature when requested.

_____ _____

Staff Signature Date

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