



## HIPAA/NOTICE OF PRIVACY PRACTICE

In accordance with HIPAA laws this notice describes how your health information may be used or disclosed and how you, the patient, can access this information. Please review the following carefully.

The law permits us to use or disclose your health information to the following:

- Another Specialist or physician who is involved in your care.
- Your insurance company, for the purpose of obtaining payment for our services.
- Our staff for the purpose of entering your information into our computerized system.
- Other entities during the course of your treatment, in order to obtain authorizations, referral visits, scheduling of tests, etc. Much of this information is sent via fax which is permitted use allowed by law. We have on file with these sources' verification of confidentiality of the fax use and its limited access by authorized personnel.
- If this practice is sold your healthcare information will become property of the new owner.
- We may release some or all of your health information when required by law. Except as described above, this practice will not use or disclose your health information without your prior written authorization.

Federal and state law allows us to use and disclose our patients' protected health information in order to provide health care services to them, to bill and collect payments for those services, and in connection with our healthcare operations.

We also use a shared Electronic Medical Records system that allows both our physicians and staff and certain participating physicians of the U Wellness Surgical and their staff access to our patients' health information. The purpose of the access is to expedite the referral of patients within the U Wellness Surgical and to assist in providing and managing their care in a coordinated way. Information in the Electronic Medical Records System can be released outside the U Wellness Surgical system only when the patient expresses authorization or as otherwise specifically permitted or required by law.

The law also establishes patient rights and our responsibility to inform you of those rights. These include:

- You have the right to request in writing any uses or disclosures we make with your health information beyond normal uses referenced above.
- You have the right to limit the user or restrict the use of disclosure of your health information. Our office will follow any restrictions notated by you on the reverse side of this form.
- You have the right to request in writing to inspect and/or receive a copy of your health information. Our office may charge a reasonable fee to cover copying and mailing of these records. -You have the right to request an alternative means or location to receive communications regarding your health information.
- You have the right to request in writing an amendment or change to your health information. Our office may agree or disagree with your request, but we'll be happy to include your statement as part of your records. If an agreement to amend or change is acceptable, please be advised that previous documentation is considered a legal document and cannot be deleted or removed. Our office will simply notate the amendment and the reason for it and add it to your record.



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We may use your information to contact you. For example, we may mail you an appointment reminder card or call you with information regarding your care. If you are not home, this information may be left on your answering machine or with the person who answered the phone. In an emergency, we may disclose your health information to a family member or another person designated responsible for your care

- Ok to speak with Spouse: \_\_\_\_\_
- Ok to speak with family member(s) listed here: \_\_\_\_\_
- Ok to leave health information on an answering machine or voicemail. \_\_\_\_\_
- DO NOT RELEASE ANY INFORMATION TO ANYONE OTHER THAN MYSELF (PATIENT)
- DO NOT RELEASE TO: \_\_\_\_\_

We reserve the right to change our privacy practices and conditions of this notice at any time and without prior notice. In the event of changes, an updated notice will be posted and our office will notify you of the changes in writing. You have the right to file a complaint with the Department of Health and Human Services, 220 Independent Avenue, S. W., Room 509F, Washington, DC 20201. Our office will not retaliate against you for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact us at (925) 430-5613.

### ACKNOWLEDGEMENT

This acknowledges that you have received and read a copy of our Privacy Practice Notice. This document is not a contract, authorization, release, or consent form. This document will remain as part of your records.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



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## TELEHEALTH DISCLAIMER

1. Please be advised that communicating via telehealth/telehealth video is not secure communication. By receipt of this telehealth/telehealth video disclaimer you understand the potential risk inherent with telehealth/telehealth video communication and agree to accept the possible risk and use telehealth/telehealth video communication as a way for you and this office to communicate.
2. I understand that U Wellness Surgical does not and cannot guarantee the confidentiality of any telehealth/ telehealth video communications and will not be liable for improper disclosure of confidential information and/or breaches of confidentiality caused by me or a third party. I understand that U Wellness Surgical has no control over the security or management of my individual internet service provider and cannot guarantee that information will not be intercepted, altered, or read by an unintended recipient.

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_