

**HIPAA – YOUR RIGHTS AND PRIVACY RULES CONCERNING
HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT**

Southwest Physicians Group will practice the following rules and procedures:

- You have a right to a copy of this notice of privacy practices;
- Your chart of information is kept secure and private;
- All staff members will have access to your chart;
- Any information released by us must have your consent;
- You have the right to your records and may request to amend them;
- We have the right not to amend, we will keep your request a permanent part of your chart;
- A diagnosis is always necessary when discussing or sharing information about your health care with laboratories, hospitals, other physicians, and insurance companies to obtain payment (this includes demographics also);
- Workman's compensation cases will still be treated under the government provision act;
- You have the right to complain to the privacy official if you do not feel that your rights are being protected. Contact the designated authority at Southwest Physicians Group, at (708)423-2880, if your rights are breached. The employee will be reprimanded, termination of employment will occur after three offenses, and you will be notified of the consequence;
- You have the right to revoke your written consent at any time, except when the use or disclosure has already happened.

SAFEGUARDS

- It is our policy to shred every document when destruction is necessary;
- We will use confidential sign in sheets;
- We will never use your information for marketing or fund-raising;
- You may be asked to verify to whom we are speaking to;
- We **will not fax** information about you for security purposes other than to **other health professionals**.

COMMUNICATION METHODS

Because it is necessary to use your diagnosis on referrals, lab requests and mail-in prescriptions, we must obtain authorization from you. May we contact you about your follow up exams, pap smears, mammograms, blood work, diabetic exams, etc.? By telephone or mail as usual? If we leave a message at your home it will be brief, example: call your doctors office at (708)423-2880. If you do not want us to use these methods, please state so below.

- Your right to request that we communicate with you about your health care in the following manner:

Please instruct us of the method of release we can use by checking one or more of the following:

_____ In case of an emergency call: Name _____

Relationship: _____ Phone#: (____) _____

_____ You may contact me by mail.

_____ You may contact me by phone (caller ID may appear) and leave messages on answering machines or with family Members.

_____ You may release immunization and necessary Rx list to educational institutions.

_____ You may release any information about me to my friends and family that I have listed below (please provide names and phone numbers).

(1) _____
Name, Relationship & Phone Number

(3) _____
Name, Relationship & Phone Number

(2) _____
Name, Relationship & Phone Number

(4) _____
Name, Relationship & Phone Number

_____ **Do not ever release information to anyone other than me unless it is to my insurance carrier or other healthcare professionals.**

I HAVE READ AND RECEIVED THE HIPAA NOTICE OF PRIVACY PRACTICES AND RULES

X _____
Signature of Patient *Date* *Print Name* *Date of Birth*

X _____
Signature of Parent/Legal Guardian *Relationship to the Patient*

Witness: _____ Date: _____