PRIVACY Name_____Date_____

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all health information used or disclosed by us is kept properly confidential. This Act gives you, the patient, rights to understand and control how your health information is used. We are required by HIPPA to maintain the privacy of your health information and explain how we may use and disclose your health information, as follows, for: Treatment; Payment; Health care operations. **Treatment** means providing, coordinating, or managing health care and related services by health care providers. An example is a physical examination. **Payment** means obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example is sending a bill for your visit to your insurance company for payment. **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example is an internal quality assessment review. We may also create and distribute de-identified health information by removing all references to individually indentifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. You may exercise the following rights regarding your protected health information, by presenting a written request to the Privacy Officer at 1 S.E. 4th Avenue, Delray Beach, FL 33483: The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it. The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations. The right to inspect and copy (copy fee may apply) your protected health information. The right to amend your protected health information. The right to receive an accounting of disclosures of protected health information. The right to obtain a paper copy of this notice from us upon request. We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices regarding protected health information, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to revise the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post, and you may request a written copy of, revised Notice of Privacy Practices from this office. You have the right to file a written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. Contact us if need more information: Privacy Officer Delia Weiss MD PA 561 243-8783 1 S.E. 4th Avenue, Delray Beach, FL 33483. For more information about HIPAA or to file a complaint: The U.S. Department of Health & Human Services Office of Civil Rights 200 Independence Avenue, S.W. Washington, D.C. 20201 (202)619-0257 Toll-Free: 1-877-696-6775. I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. Obtain payment and third-party payers. Conduct normal healthcare operations such as quality assessments and physician certifications. I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that Delia Weiss MD PA has the right to change its Notice of Privacy Practices from time to time and that I may contact Delia Weiss MD PA at any time at the address above to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Signature:_____Date_____

Name (print and sign) and Relationship if Patient unable to sign:_____
Date_____