



Lifenrg@verizon.net

Notice of Privacy Policies
For
Village Square Health & Wellness

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) as amended by the Health Information Technology for Economic and Clinical Health Act (“HITECH”), is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, be kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. “HIPAA” provides penalties for covered entities that misuse personal health information (PHI).

As required by “HIPAA”, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be 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 would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable 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 action relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to our Privacy Officer:

- 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 unless the requested restriction (i) relates to disclosures to a health plan for payment and/or health care operations, and (ii) the PHI relates to a health care service or product for which you have paid in full and out of your own pocket.
- 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 your protected health information.



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- The right to amend your protected health information.
- The right to receive an accounting of disclosures made of your health information; by submitting a written request, as provided by 45CFR § 164.528 and the HITECH Act;
- revoke your authorization to use or disclose health information except to the extent that action has already been taken.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to:

- maintain the privacy of protected health information and notify you in the event of a breach if the breach poses a significant risk of financial, reputation, or other harm to you;
- provide you with this notice of its legal duties and privacy practices with respect to your health information;
- abide by the terms of this notice;
- notify you if we are unable to agree to a requested restriction on how your information is used or disclosed;
- accommodate reasonable requests you may make to communicate health information by alternative means or at alternative locations; and
- obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.”

This notice is effective February 17, 2010 and we are required to abide by the terms of this Notice of Privacy Practices currently in effect. We reserve the right to change 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 a revised Notice or Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violation of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

If you believe your privacy rights have been violated and wish to file a complaint with the practice's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health & Human Services, the address for the OCR is listed below

Please contact us for more information:
Complete Care Health & Medical
Compliance Officer: Harold Cohen
7 Village Square
Glen Cove, NY 11542
(516) 759-2032, Fax (516) 759-2117

Office for Civil Rights
U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201
(202) 619-0257 Toll-Free (877) 696-6775

I acknowledge that I have received this notice.

Name (print)

Signature of patient/Legal representative

Date

Form 701 HIPPA