NOTICE OF PRIVACY PRACTICES

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

Uses and Disclosures

Treatment – Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment – Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided and the medical condition being treated. The information on the bill may contain information that identifies you, your diagnosis and treatment.

Health Care Operations – Your health information may be used as necessary to support the day-to-day activities and management of Gulf Coast OB/GYN, PA. For example, information on the services you received may be used to support budgeting and financial reporting and activities to evaluate and promote quality of care.

Law Enforcement – Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations and to comply with government mandated reporting. For example, to report information related to victims of abuse, neglect, domestic violence or respond to judicial and administrative proceedings and subpoenas.

Public Health Reporting – Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purposes other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes when financial remuneration is involved. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

Worker's Compensation – Your health information may be used or disclosed in order to comply with laws and regulations related to worker's compensation.

Appointment Reminders – Your health information will be used by our staff to send you appointment reminders.

Information about Treatments – Your health information may be used to send you information on the treatment and management of your medical condition that you may find interesting.

We may send you information describing other health-related products and services that we believe may interest you.

Individual Rights
You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information. We may deny your request for certain specific reasons. If we deny your request, we will provide you with a written explanation for the denial and information regarding further rights you have at this point.
- The right to receive an accounting of how and to whom your protected information has been disclosed.
- The right to receive a printed copy of this notice.

Gulf Coast OB/GYN, PA Duties
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices outlined in this notice. In the event of a breach of unsecured protected health information, if your information has been compromised, it is our duty to notify you.

Right to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the FRONT DESK or PRIVACY OFFICER. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints and Contact Person
If you would like to submit a comment or complaint about our privacy practices, or if you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter to:

Privacy Officer
Gulf Coast OB/GYN, PA
4507 Hospital Street
Pascagoula MS 39581-5336
228-769-1940 ext. 221

You will not be penalized or otherwise retaliated against for filing a complaint.

This notice is effective on or after 07/08/2016

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

Gulf Coast OB/GYN, P.A., reserves the right to modify the privacy practices outlined in the notice.

YES ______ I have received a copy of the Notice of Privacy Practices (HIPAA) for Gulf Coast OB/GYN, PA.

I give permission to the physicians and staff of Gulf Coast OB/GYN, PA to release to the person(s) listed below my:

_______ Medical Information
_______ Financial Information

NAME RELATIONSHIP PHONE NUMBER

_______ Medical Information
_______ Financial Information

NAME RELATIONSHIP PHONE NUMBER

_______ Medical Information
_______ Financial Information

NAME RELATIONSHIP PHONE NUMBER

Who is your Primary Care Physician? ____

May we share your health information with your PCP, if they request it? ______ Yes _______ No

List other physicians you would like us to share your health information with, if they request.

____________________________ ______________________________ ______________________

NAME of PATIENT (Please Print)

SIGNATURE of PATIENT

DATE

NAME of PATIENT REPRESENTATIVE (Please Print)

SIGNATURE of PATIENT REPRESENTATIVE (Required if the Patient is a Minor or an Adult who is unable to sign this form.)

RELATIONSHIP of REPRESENTATIVE to PATIENT (Please Print)

EMPLOYEE WITNESS SIGNATURE