

NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **Personal Health Information**. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a copy of this information, one will be provided to you. Once you have read this notice, please sign the last page, and return only the signature page to our front desk receptionist. Keep this page for your records. If you are filling this out online, then save this policy to your computer for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care.
2. Inadvertent disclosures- open front desk area means open discussion. Be aware that if you speak about your condition(s) in the front desk area then it will be possible for people to hear you. If you need to speak privately to the doctor, please wait until you are in the treatment area or the doctor's office.
4. Emergency- in the event of a medical emergency we may notify a family member.
5. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
6. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
7. For military, national security, prisoner and government benefits purposes.
8. Deceased persons –discussion with coroners and medical examiners in the event of a patient's death.
9. Telephone calls or emails and appointment reminders -we may call your home and leave messages regarding a missed appointment or apprise you of changes in practice hours.
10. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS:

1. To receive an accounting of disclosures.
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice

3. To request mailings to an address different than your residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance (72 hours).
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain one copy of your records at no charge, when timely notice is provided (72 hours).

COMPLAINTS:

If you wish to make a formal complaint about how we handle your health information, please email the office at prosperhealthclinics@gmail.com. We will contact you and you will be able to schedule an appointment with our receptionist within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to: DHHS, Office of Civil Rights 200 Independence Ave. SW Room 509F HHH Building Washington DC 20201

I have received a copy of Prosper Health Clinic's Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information.. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice" at any time in the future and will make the new provisions effective for all information that it maintains past and present. I understand that I will be notified of any amendments or provisions made in regards to this Notice.

I am aware that I am entitled to a physical copy of this notice upon request. At this time, I do not have any questions regarding my rights or any of the information I have received.

Patient's Name _____ D.O.B. ____/____/____

Patient's Signature _____ Date ____/____/____

Witness _____ Date ____/____/____