Quality Physician Group

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Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information", we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues

- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why...
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-base fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the per.mn has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways - usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health Information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services If It wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health Information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual die.

Address workers' compensation, law enforcement, and other government requests

We can use or share health Information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this no ice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more Information see: www.hl1s.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other Instructions for Notice

- Effective Date of this Notice: December 3, 2018, until further changes are disclosed.
- Privacy official contact: Office Manager or via email: info@qualityphysiciangroup.com

_____ _____

Patient Signature Date

Quality Physician Group
33049 Professional Drive, Suite 103
Leesburg, Florida 34788
Phone: 352-353-6967 **Fax:** 855-642-1936

Authorization for Release of Medical Records:

Patient's Name:_____ Date of Birth:_____

Patient's Address:_____

_____ _____

I hereby authorize Release of Medical Information:

From:_____ Fax:_____

To: **Ana Karovska Vuchidolov. MD** **Fax:855-642-1936**

This Information is subject to limitation as Indicated below (patient must initial all responses):

( ) Covering Medical Records for office visits, labs diagnostic studies, procedures etc.

For the last_____months / years or Since_____

( ) No limitations placed on dates, history of mental Illness, or diagnostic and therapeutic information, Including any treatment for alcohol or drug abuse, infectious disorders Including HIV/AIDS test results and/or status.

( ) Confined to Medical Records or information regarding the diagnostic and treatment of the following medical conditions:_____

I understand and acknowledge that this authorization extends to all of any part of the records designated above, which may include treatment for physical *and* mental illness, alcohol/drug abuse and/or HIV/AIDS test results or diagnoses.

Law protects the confidentiality of the above medical records against further disclosure. Except as implicit in the purpose of this disclosure, Federal regulations (42CFR, Part 2) prohibit recipient (s) from making any further disclosure or It without the specific written consent of the person (s) to whom it pertains, or as otherwise permitted be such regulation. A General authorization for the release of medical or other information is NOT sufficient for this purpose.

This authorization is subject to written revocation at any time except to the extent that action has already been undertaken is reliance thereon and is valid for 60 days.

Signature:_____ Date: _____/_____/_____
(Parent or guardian 1 if patient is a mirror)

Witness: _____

Emergency Contact Form

Ensure that the information on this form is validated and updated periodically.

Personal Information | Date when this form was filled or updated:

Name: _____

Work Address: _____

City State Zip code

Home Address: _____

City State Zip code

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail (Home): _____ E-mail (Work): _____

Primary person to be notified in case of an emergency:

Name: _____

Relationship: Relative _____ Friend _____ Other _____

Home Address: _____
Street Address City State Zip code

Home Phone: _____ Work: Phone: _____ Cell Phoner: _____

E-mail Address: _____

Secondary person to be notified in case of an emergency:

Name: _____

Relationship: Relative _____ Friend _____ Other _____

Home Address: _____
Street Address City State Zip code

Home Phone: _____ Work Phone: _____ Cell No. _____

E-mail Address: _____

The information requested on this form is confidential and for emergency use only. In the event of a medical emergency, this information will be used by _____ .and emergency personnel.

Please ensure that the form has the most updated & accurate info.

In the case of emergency, I give pe;1nission for my information to be released to emergency personnel. I also agree that any of my emergency contacts listed on this card may i.>e notified in an emergency, as needed.

Signature: _____ Date: _____

Medical Information Release Form

(HIPPA Release Form)

Name:_____ Date of Birth: _____

Release of Information

I authorize the release of information including the diagnosis records examination rendered to me and claims information. This information may be released to:

Spouse:_____

Child(ren):_____

Other: _____

[ ] Information is not to be released to anyone.

This ***Release of information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell number:_____

If unable to reach me:

[] you may leave a detailed message

[] please leave me a message asking me to return your call

[] _____

The best time to reach me is (day)_____between (time)_____

signed:_____ Date: _____/_____/_____

witness·._____Date: _____/_____/_____