NOTICE OF PRIVACY

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.

If you have any questions about this Notice please do not hesitate to ask.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices.

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice. We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object: required by law, public health reasons, communicable diseases, required by the FDA, abuse or neglect of a patient, workers' compensation, inmates under treatment.

2. Your Rights

You have the right to inspect and copy your protected health information. As permitted by federal or state

law, we may charge you a reasonable copy fee for a copy of your records.
You have the right to request a restriction of your protected health information and ask us not to disclose your information to certain individuals.
You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests.
You may have the right to have your physician amend your protected health information if you believe it is incomplete or inaccurate.
You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.
If you wish to receive an email communication regarding your health information or records, you acknowledge that you have been advised of the risk of transmission of this information, understand that this is not a secure format, acknowledge that this information may be seen by a third unauthorized party and take full responsibility of the possible security breach.
I authorize the following **to have access** to my Protected Health Information:

______________________________ ________________________
Print Name Relationship

______________________________ ________________________
Print Name Relationship

______________________________ ________________________
Print Name Relationship

I give my permission for Pandya Medical Center and its staff t**o leave messages/communications** about my health, medical results, lab results or appointment on the following numbers:
HOME: ____
MOBILE/CELL: ____
WORK: ____

Receipt of Notice of Privacy Practices

Written Acknowledgement

I, _________________________have received a copy of Notice of Privacy from Pandya Medical Center.

Signature of Patient or Guardian: ________________________________ **Date:**_____/_____/_____