HARPER & ASSOCIATES FAMILY MEDICINE, PC

PRIVACY POLICIES

ACKNOWLEDGEMENT OF RECEIPT

I, _____acknowledge receipt of the Notice of Privacy Practices of this said practice.
(Insert your printed name)

_____ _____
(Patient/parent signature) (Today's date)

It is the policy of our practice that all physicians and staff preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice and its physicians and staff have the necessary medical and PHI to provide the highest quality medical care possible while protecting the confidentiality of the PHI of our patients to the highest degree possible. Patients should not be afraid to provide information to our practice and its physicians and staff for purposes of treatment, payment and healthcare operations (TPO). To that end, our practice and its physicians and staff will –

- Adhere to the standards set forth in the Notice of Privacy Practices.
- Collect, use and disclose PHI only in conformance with Georgia and federal laws and current patient covenants and/or authorizations, as appropriate. Our practice and its physicians and staff will not use or disclose PHI for uses outside of practice's TPO, such as marketing, employment, life insurance applications, etc., without an authorization from the patient.
- Use and disclose PHI to remind patients of their appointments only with their consent.
- Recognize that PHI collected about patients must be accurate, timely, complete and available when needed. Our practice and its physicians and staff will –
    - ✓ Implement reasonable measures to protect the integrity of all PHI maintained about patients.
- Recognize that patients have a right to privacy. Our practice and its physicians and staff respect the patients individual dignity at all times. Our practice and its physicians and staff will respect patient's privacy to the extent consistent with providing the highest quality medical care possible and with the efficient administration of the facility.
- Act as responsible information stewards and treat all PHI as sensitive and confidential. Consequently, our practice and its physicians and staff will:
    - ✓ Treat all PHI data as confidential in accordance with professional ethics, accreditation standards, and legal requirements.
    - ✓ Not disclose PHI data unless the patient (or his/her authorized representative) has properly consented to or authorized the release or the release is otherwise authorized by law.
- Recognize that, although our practice "owns" the medical record, the patient has a right to inspect and obtain a copy of her PHI. In addition, patients have a right to request an amendment to her medical record if she believes that her information is inaccurate or incomplete. Our practice and its physicians and staff will –
    - ✓ Permit patients access to their medical records when their written requests are approved by our practice. If we deny their request, then we must inform patients that they may request a review of our denial. In such cases, we will have an on-site healthcare professional review the patient's appeals.
    - ✓ Provide patients an opportunity to request the correction of inaccurate or incomplete PHI in their medical records in accordance with the law and professional standards.
- All physicians and staff of our practice will maintain a list of all disclosures of PHI for purposes other than TPO for each patient. We will provide this list to patients upon request, so long as their requests are in writing.
- All physicians and staff of our practice will adhere to any restrictions concerning the use or disclosure of PHI that patients have requested and have been approved by our practice.
- All physicians and staff of our practice must adhere to this policy. Our practice will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action, up to and including termination of employment and criminal or professional sanctions in accordance with our practice's personnel rules and regulations.
- Our practice may change this privacy policy in the future. Any changes will be effective upon the release of the revised privacy policy and will be made available to patients upon request.

HARPER & ASSOCIATES FAMILY MEDICINE, PC

Patient Consent for Use and Disclosure
of Protected Health Information

I hereby give my consent Harper & Associates Family Medicine, PC to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO) Harper & Associates Family Medicine, PC's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Harper & Associates Family Medicine, PC reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Harper & Associates Family Medicine, PC, Privacy Officer, at 5910 Hillandale Drive Suite 301, Lithonia, Georgia 30058.

With this consent, Harper & Associates Family Medicine, PC, may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among them.

With this consent, Harper & Associates Family Medicine, PC, may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements, and lab results as long as they are marked Personal and Confidential.

With this consent, Harper & Associates Family Medicine, PC, may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Harper & Associates Family Medicine, PC, restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Harper & Associates Family Medicine, PC's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Harper & Associates Family Medicine, PC, may decline to provide treatment to me.

_____
Signature of Patient or Parent/Legal Guardian

_____
Patients Full Name Today's date

_____
Printed Name of Patient or Parent/Legal Guardian