Notice of Privacy Practices

This practice is determined to protect the privacy of your medical information. As we provide service to you, we create and store health information (a medical record) that identifies you. It is often necessary to share or disclose this health information in order to provide treatment for you, obtain payment and to conduct healthcare operations in our office.

This Notice of Privacy Practices requires us to:

1. Keep your medical records private and to provide you with this notice.
2. Change our privacy practices and the terms of this notice at any time, ensuring our notice is effective, even for information recently obtained.
3. Before we make an important change in our privacy practices, we would change this notice and make the new notice available upon request.

You have individual rights as part of the notice of Privacy Practices. As a patient of Coastal Audiology and Hearing Aid Center, you have the right to:

1. Photocopies of your medical records on file and/or a copy of this Notice of Privacy Practices. If you need a photocopy, please notify the receptionist.
2. Receive a list of all the times your medical information has been shared by our office or our business associates, other than treatment, payment, healthcare operations and/or other specified exceptions.
3. Request we communicate with you about your medical information by different means or to different locations. This request must be made in writing to Coastal Audiology & Hearing Aid Center.
4. Request a change to your health information if you think it is incomplete or inaccurate. However, if the audiologist, hearing healthcare professional or office personnel believe the patient's health information is complete and accurate, he/she can refuse to make the requested changes. This request must be made in writing to Coastal Audiology & Hearing Aid Center.
5. Request a paper copy if you have received this Notice of Privacy Practices electronically. This request must be made in writing to Coastal Audiology & Hearing Aid Center

The following is a description of the different circumstances that may require this practice to use or disclose your medical information:

1. Share medical data with another provider who is responsible for your care (physicians, audiologists, nurses, any other healthcare professionals, technicians, students in healthcare, or any other people who take care of you), make referrals and/or placing lab/prescription orders.
2. Share your health insurance plan information about a treatment you received at our practice when filing a claim for reimbursement or determination of benefits.
3. Disclose your medical information for our healthcare operations.
4. Share information about your condition(s), location and/or death to family member(s), or your personal representative(s). Prior permission by you will be obtained unless in case of emergency. If we are unable to obtain permission, we will share only the health information directly necessary for your healthcare.
5. Disclose medical information to a medical examiner to identify a deceased person or to determine the cause of death, or for tissue donations.
6. Medical information may be disclosed if you are military personnel, either active or a veteran, and if required by the appropriate authorities.
7. Share medical data to the public health and/or law enforcement official whose job is to prevent or control disease, injury or disability.
8. Share medical data to a representative from the Food and Drug Administration for the purpose of reporting adverse effects stemming from defective products, etc
9. Medical information may be disclosed when necessary to comply with Workers' Compensation.
10. Medical information may be disclosed when in response to a court and/or administrative order in a lawsuit or similar proceeding.

Communication to our Patients

The HIPAA Final Privacy Rule permits an individual to request that communication from our office be received in a confidential manner. You may ask to be contacted in a certain way, such as, only contacting by mail or at a specified telephone number.

I can be contacted in the following manner *(please check ALL that apply)*:

☐ Home Telephone _____

☐TEXT appt. reminder to _____

☐O.K. to leave a message with detailed information

☐O.K. to mail to my home address

☐Leave message with call back number only

☐O.K. to mail to my work/office

☐Work telephone_____

☐O.K. to fax to this #_____

☐O.K. to leave a message with detailed information on voicemail or with _____

☐Leave message with callback # only

☐O.K. to email to this email address_____

Persons involved in your care

The HIPAA Final Privacy Rule provides you the right to agree or object to the use or disclosure of information to a family member or close friend who is involved in your care.

You may leave messages with, discuss my treatment, appointments, or other scheduling that may occur or give other information as necessary with the following family, friends, or personal representatives. I understand Coastal Audiology and Hearing Aid Center will refuse to discuss my information with anyone not listed below, except in an emergency. I also understand that this does not apply to medical providers. I can edit this list at any time by providing, in writing, any changes.

PLEASE PRINT: NAME **CONTACT NUMBER** **RELATIONSHIP**

1._____

2_____

3_____

4_____

Patient Signature_____ Date_____