THE PLASTIC SURGERY CENTER of East Tennessee

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our Privacy Practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it. We reserve the right to change our policy practices and the terms of this Notice at any time, provided such changes are permitted by law. You may request a copy of our Notice at any time.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations.

Treatment: In conjunction with any healthcare provider providing treatment to you.
Payment: To obtain payment for services we provide to you.
Healthcare Operations: In connection with our healthcare operations for administrative purposes to efficiently and effectively run our practice.
Your Authorization: We may need to use or disclose your health information to others concerning appointment confirmation, information about treatment, or other health related information that may be of interest to you. You may give us written authorization to do so. If you give us written authorization you have the right to revoke it at any time.
To your family and friends: With your written authorization, we may disclose information to a family member, or friend, or other person to the extent necessary to aid you with healthcare or payment.
Required by Law: We may use or disclose your health information when we are required by law.
Abuse or Neglect: If reasonable evidence points to possible abuse, neglect, domestic violence, or other crimes, we reserve the right to report the matter to the proper authorities to insure your safety.

PATIENT RIGHTS

Your rights under this notice are as follows:

Access: To look at or get copies of your health information with limited exceptions. You must make this request in writing. A reasonable fee may be charged for expenses such as copies and staff time.
Disclosure Accounting: To receive a list of instances in which your information was disclosed, other than treatment, payment, and healthcare operations for the last six years, but not before April 14, 2003.
Restrictions: To request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to the request, but if we do, we will abide by our agreement (except in an emergency).
Amendment: To request that we amend your health information. The request must be in writing, and it must explain why it should be amended. We may deny your request under certain circumstances.
Complaints: To complain to us or the Department of Health and Human Services if you feel your rights have been violated. While you may make an oral complaint at anytime, written complaints should be addressed to the above address.

Phone: 423-392-4884
Fax: 423-392-4820
One Sheridan Square, Suite 200
Kingsport, TN 37660
www.theplasticscenter.com

PATIENT REQUEST FOR RESTRICTIONS
of the USE and/or DISCLOSURE
of their PROTECTED HEALTH INFORMATION

As required by the Health Insurance Portability and Accountability Act of 1996, you have the right to request restrictions regarding the use or disclosure of your protected health information. The physician practice is not required to agree to the restrictions but will attempt to accommodate all reasonable requests and no request will be refused based on a perception of the merits of the request.

Today's Date: ______________________ Patient Name: ______________________________

MR#: ______________________________ Registration #: ______________________________

I, ____ (print name) request the following restriction on the use or disclosure of my health information: ____
____
____
____
____
____
____
____

If the request is for alternate communication channels, an alternate address and telephone number must be provided. Requests for alternate communications can not be accepted without this information.

I understand that all requests will apply only to this registration period; and if accepted the request will terminate upon each discharge.

NOTE: request for NO information to be disclosed in the facility directory should be documented on the Consent to Treat form in the Admitting Department and entered in the hospital information system.

____ ______________________________

Signature of Patient or Legal representative Date

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To be completed by the Practice Manager: Request has been: _____accepted __________denied. Date: ______________________

Reviewer's comments: ____
____
____

Actions taken: ____
____

____ ___________________________________

Signature of Physician Practice Reviewer Date