NOTICE OF PRIVACY PRACTICES

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.

Effective Date: 04/13/2003

Our Pledge Regarding Your Health Information

We understand that medical information about you and your health is personal. We create a record of the care and services you receive from us. We need this record to provide you with quality care, obtain payment for the services we provide, and to comply with legal requirements. This notice applies to all of the records of your care generated by us, whether made by your personal doctor, other Practice doctors, or Practice staff. We are required by law to 1) make sure that medical information that identifies you is kept private; 2) give you this Notice of our legal duties and privacy practices; and 3) follow the terms of the Notice that is currently in effect. The professional and non-professional staff at our Practice will follow the terms of this Notice.

How We May Use and Disclose Medical Information About You

The following categories and examples describe the different ways that we use and disclose medical information. Not every use and disclosure in a category will be listed. However, all the ways we are permitted to use and disclose information will fall within one of the categories.

Category:	Description and Examples:
Treatment	We may share medical information about you with another physician, a hospital, or other health care provider involved in you care. For example, a hospital may need to see part of your medical record before you have surgery.
For Payment	We may share medical information with Medicare or other health plan to obtain payment for services provided to you, to verify insurance coverage, or to obtain authorization for further treatment. For example, an insurance company may need to see part of your medical record before they will pay for the services.
For Practice Operations	We may share medical information as necessary to manage the medical, legal, and financial affairs of the Practice and to monitor the quality of services provided to our patients. For example, our attorney or accountant may need patient information in order to provide legal and financial services to the Practice. Any business associate with whom we share medical information will agree in writing to protect your privacy.
Appointment Reminders	We may disclose medical information to remind you of an appointment. We will disclose only the date, time, and location of the appointment.
Family Members & Friends	We will share medical information with a friend or family member who is involved in your care or payment of your bill. We will give you an opportunity to agree or object to these disclosures unless it is clear from the circumstances that you do not object.
Workers Compensation	We may report a work-related injury to a worker compensation carrier or to advise your employer about a work-related injury.
To meet legal requirements and for public health activities	We may disclose medical information to a government agency that oversees medical practice in the State such as Florida Agency for Health Care Administration or the Board of Medicine. We are also required to report certain diseases and conditions to the local unit of the Department of Health for its public health activities.
Law enforcement, lawsuits, disputes, and reports of abuse or neglect	We may disclose medical information to an attorney or a law enforcement official to comply with a court order, subpoena, discovery request, or other legal mandate. We may also disclose medical information to assist law enforcement with investigating crime. For example, we are required to report wounds resulting from violence and incidents of abuse or neglect.
To avert a serious threat to health or safety	We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or that of the public or another person. Any disclosure, however, would only be to someone able to respond to the threat.
For special Government Functions	We may be required to disclose medical information to a government agency for national security purposes, a correctional facility in which you may be incarcerated, or to a military authority if you are in the service or a veteran.
Organ and tissue Donation	We may disclose medical information to an organization that handles organ, eye, or tissue transplantation.
Medical Examiners And Funeral Directors	We may release medical information to a coroner or medical examiner to identify a deceased person or determine the cause of death. We may also release medical information about individuals to funeral directors as necessary to carry out their duties.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Your Rights Regarding Medical Information

You may access your medical information	To access your medical information, you must submit your request to us at the address listed at the end of this Notice. If you request copies, we may charge a fee allowed by law. We may deny your request in certain very limited circumstances. For example, we might deny access to psychotherapy notes that might be a part of your record.
You may amend or correct your medical information	You may ask us to amend or correct your medical information. Please make your request in writing and submit it to the address listed at the end of this Notice. You must provide a reason that supports your request.
You may request an "accounting of disclosures"	You may request a list of the disclosures we made of medical information about you, other than for treatment, payment, or Practice operations as described above, and without your written authorization.
You may request restrictions on the use or disclosure of your medical information	You may request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or Practice operations. For example, you could ask that we not share information about your surgery you had with a family member or friend. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.
You may request confidential communications	You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. We will try to accommodate all reasonable requests.
You may have a paper copy of this Notice	You have the right to a paper copy of this Notice. You may ask us to give a paper copy of this Notice at any time, even if you obtained a copy electronically.

Changes to this Notice

We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for medical information we already have about you, as well as any information we receive in the future. We will post a copy of the current Notice in prominent locations at our Practice site. The Notice will contain the effective date.

Exercise of Privacy Rights and Complaints

To exercise your privacy rights or file a complaint, contact us at our address below. A complaint may also be filed with the Secretary of the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

Ted F. Kadivar, M.D., P.A.
250 2nd St. East, Suite 4C
Bradenton, FL 34208
941-744-5860 Phone
941-744-5681 Fax

Office for Civil Rights
U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone_____
- ☐ OK to leave message with detailed information
- ☐ Leave message with call back request only

☐ Work Telephone_____
- ☐ OK to leave message with detailed information
- ☐ Leave message with call back request only

☐ Written Communication
- ☐ OK to mail to my home address
- ☐ OK to mail to my workplace address
- ☐ OK to fax to this number:_____

Other:_____
_____
_____

_____/____/_____
Patient's Signature Date Signed

_____/____/_____
Witness's Signature Date Signed