OVERLAKE FAMILY MEDICINE
HIPAA NOTICE OF PRIVACY PRACTICES

Effective date: April 14, 2003

We understand that health information about you and your health is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all records for your care generated by this office, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- Make sure that health information that identifies you are kept private
- Give you this Notice of our legal duties and privacy practices with respect to health information about you
- Follow the terms of the Notice that is currently in effect

We may use and disclose health information about you:

- For treatment
- For payment
- For health care operations
- For appointment reminders
- As required by Law
- To avert a serious threat to health and safety
- As required by the Military or Veterans and Workers Compensation
- Public Health risks
- Health oversight activities
- Lawsuits and disputes
- Law enforcement
- Coroners, health examiners and funeral directors
- National and security and intelligence activities
- Protective Services for the president and others
- Security officials for inmates

Your rights regarding Health Information about you:

- Right to inspect and copy
- Right to amend
- Right to an accounting of disclosures
- Right to require restrictions
- Right to request confidential communications
- Right to a paper copy of this notice

Changes to this Notice:

We reserve the right to change this notice. We will post a copy of the current notice in our facility with the current effective date.

Complaints:

If you believe that your privacy rights have been violated, you may file a complaint with us. All complaints must be in writing. Please contact the clinic administrator at our office to file a complaint.

Acknowledgement of receipt of this notice:

We will request that you sign a separate form acknowledging you have received a copy of this notice. This acknowledgement will become part of your records.

OVERLAKE FAMILY MEDICINE

PATIENT CONSENT FORM

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a Patient Rights section describing your rights under the law. You have the right to review our notice before signing the consent. The terms of the notice may change. If we change our notice, you may obtain a revised copy on our web site or by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to these restrictions, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
- The patient has the right to revoke this consent in writing at any time and all future disclosures will then cease.

This consent signed by: _____ Date: _____

Print Name: _____

Relationship (if other than patient):_____

Witness: _____
(practice representative)

OVERLAKE FAMILY MEDICINE

CONSENT TO LEAVE MESSAGES

We at Overlake Family Medicine are working to insure the confidentiality regarding your Protected Health Information and care is maintained at all times. Due to confidentiality concerns and to comply with the HIPAA act of 1996, we need your signature to allow us to leave messages about your upcoming office visits, account information, and/or any test results you may want us to convey to you via telephone or electronic messaging.

Please complete and sign this form, indicating your preference.

I _____ give Overlake Family Medicine permission to:

- Leave a message regarding my upcoming office visit, Account information, and test results on my answering machine. YES / NO

- Leave a message at my home with someone who answers the phone at my residence. YES / NO

- Leave a message at my place of employment. YES / NO

_____ Date: _____
(Signature)

Relationship (if other than patient): _____