Dr. Shuan Chavez, D.MD., P.C

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.

Federal and state law requires us to maintain the privacy of your health information. That law also requires us to give you this notice about our privacy practices, our legal duties and your rights concerning your health information. You may request a copy of our notice at any time.

We reserve the right to change our privacy practice policy and the terms of this notice at any time, provided such applicable law permits the changes. We reserve the right to make the change in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

Uses and Disclosures of Health Information That We May Obtain About You

We use and disclose health information about you for treatment, payment and health care operations. For Example:

Treatment: We will use your health information for treatment or disclose it to a dentist, physician or other health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may do this with insurance forms filed for you in the mail or sent electronically.

Health Care Operations: We may use and disclose your health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioners and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews.

Family, Friends and Caregivers: We may disclose your health information with those you tell us will be helping you with your home hygiene, treatment, medications or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want, we will disclose your health information based on our professional judgment of whether disclosure would be in your best interest.

On your Authorization: Other than is stated above or where Federal State or Local law requires us we will not disclose your health information other than with your written authorization. You may revoke that authorization in writing at any time.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders. They may include postcards, letters, telephone reminders or voicemail messages.

Public Health National Security and Law Enforcement: We may be required to disclose your health information to Federal officials or military authorities necessary to complete an investigation related to public health or national security. We may disclose your health information as required by law, for public health activities, including disease and vital statistic reporting, child abuse reporting, neglect or domestic

violence. We will make abuse or neglect disclosures only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.

Patients Rights

Access: You have the right to read, review and get copies of you health information, with limited exceptions. You must make a request in writing to obtain access to your health information. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Restrictions: You have the right to request restrictions on certain uses and disclosures of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. Your request is not binding unless our agreement is in writing.

Alternate Communications: You have the right to request that we communicate with you about your health by alternative means or to alternative locations. You must make your request in writing. You must specify in your request the alternative means of location, and provide satisfactory explanation how you will handle payment under the alternative means or location you request.

Amendment: You have the right to request that we update or modify your records if you believe your health information records are incorrect or incomplete. Your request must be in writing, and it must explain why we should update or modify your information. We may deny your request if the record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.

Documentation of Health Information: You have the right to request a description of how and where your health information was used by our office for any reason other than for treatment, payment or health operations over the last 6 years, but not before April 14, 2003. Your request must be in writing. Please provide us the time period for which you are interested. We may need to charge you a reasonable fee for your request.

You have the right to obtain a copy of this Notice directly from our office at any time. Stop by or give us a call and we will mail you a copy to you.

You have the right to express complaints to us or the Secretary of Health and Human Services if you believe you privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know of your concerns of complaints in writing.

Acknowledgement of receipt of privacy notice

Name: _____

Address: _____

_____

Signature of Patient or Guardian

Date: _____/_____/_____ Telephone: _____