

# **HIPAA COMPLIANCE STATEMENT**

*THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.*

At Biltmore Dermatology Associates, PA, we are committed to protecting your privacy. We comply with all federal, state, and local laws. This notice describes how we use your health information. It describes some of your rights and some of our responsibilities.

## **UNDERSTANDING YOUR HEALTH RECORD/INFORMATION**

Each time you visit our offices, we record your symptoms, physical examination, test results, diagnosis, and treatment. This information enables us to plan for your care, communicate with others who care for you, report to your insurance carrier, bill for our work, and improve the quality of our care to you.

## **YOUR RIGHTS**

Although your medical chart belongs to our practice, the information contained in the chart is yours. You have the right to inspect your records, obtain a copy of your chart for a small fee, correct your records, and tell us not to release your information to certain parties.

## **OUR RESPONSIBILITIES**

We are required to maintain the privacy of your health information, send needed health information to other medical providers, and release information to insurance companies, certain government agencies, and others. We may be required to release some information, even without your permission.

## **EXAMPLES OF HOW YOUR INFORMATION IS USED**

Your health information will be recorded and used to plan your treatment. Reports may be sent to other doctors to help them plan your treatment. Claims will be sent to your insurance company. The information in the claims will include confidential information such as your name, address, diagnosis, and treatment. In providing your care, we may communicate with other individuals or businesses. Examples include other physicians and/or laboratories. To protect your privacy, we ask our business associates to safeguard your information.

## **OTHER NOTICES**

We may leave a message at your home, at your business, on your answering machine or on your voicemail. We will communicate with you regarding your medical information by phone or written letter only. Please do not email or text our office or our staff to discuss your medical information. We may use email or texting to remind you of upcoming appointments. We may mail you a postcard or other written notices. We may need to disclose your information to your family members or other people helping with your care. In doing so, we will use our best judgment. We may disclose information to others as required by law or if subpoenaed. If you were injured on the job, we will need to disclose your health information to your workers compensation insurance company. We may, from time to time, update these policies.

## **FOR MORE INFORMATION, QUESTIONS OR TO REPORT A PROBLEM**

If you have concerns or would like additional information, you may contact the Office Manager.

**HIPPA CONSENT: Without signed consent, we can NOT share information regarding your medical care (including family). Please list anyone you would like to have this information below.**

do not wish anyone to have information regarding my care.

1. \_\_\_\_\_

2. \_\_\_\_\_

**Patient/Responsible Party Signature (HIPAA Policy)**

X \_\_\_\_\_ Date \_\_\_\_\_