HIPPA CONSENT

Lucille Belnick, M.D., P.A.
Privacy Officer: Tracy Rhodes, M.D.

5558 Lake Howell Road
Winter Park FL 32792
Phone: 407-679-3400 Fax: 407-679-3412

This practice is committed to maintaining the privacy of your health information, which includes information about your Health condition and the care treatment you receive from this practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care. This Notice details how your health information may be used and disclosed to third parties. This Notice also details your rights regarding your health information.

State and federal laws require this practice to maintain the privacy of your health information and to inform you about our Privacy practices by providing with this Notice. This practice is required by State law to maintain a higher level of Confidentiality with respect to HIV testing and sexually transmitted disease and is provided for under Federal law.

It is the right of this practice to change our privacy practices provided the law permit's the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will distribute any revised Privacy Notice to you prior to implementation upon request. We reserve the right to make any changes in our privacy practices and the new terms of the Notice effective for all health information maintained, created and/ or received by us before the date changes were made. You may request a copy of our Privacy Notice at any time by contacting our office. Typical uses and disclosures of Health Information: We will keep your health information confidential. We may use and/or disclosure health information, without a written consent from you in the following instances:

TREATMENT: In order to provide you the health care you require, the Practice may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

DISCLOSURE: In order to provide you the health care you require, The Practice will provide your health information to those health care professionals, whether on the Practice staff or not, directly involved in your care so that they may understand your health conditions and needs. These professionals will have a privacy and confidentiality policy like this one. The health information about you may also be disclosed to your family, friends and/or other persons that you choose to involved in your care, only if you agree that we may do so.

PAYMENT: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may be involved in mailing statements and/or collecting unpaid balances.

EMERGENCIES: We may use or disclose health information for the purpose of obtaining or rendering emergency treatment to you or to assist in the notification of a family member or anyone responsible for your care in the case of an emergency involving your care. If at all possible, we will provide you with an opportunity to object to this use or disclosure. We will use our professional judgment to disclose only that information directly relevant to your care.

HEALTHCARE OPERATION: In order for the practice to operate in accordance with applicable law and insurance requirements, it may be necessary to compile, use and/or disclose your health information. For example, the Proactive may use your health information in order to evaluate the performance of the Practice's personnel in providing care to you for ongoing measurement of quality assurance.

REQUIRED BY LAW: We may use or disclose health information when we are required to do so by law. This would include the court orders, subpoenas, discovery requests or other lawful processes. We will use and disclose information when requested by nation security, intelligence and other State and Federal officials and/or if you are an inmate under custody of law enforcement. The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances.

ABUSE OR NEGLECT: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or other crime. This information will be disclosed only to the extent necessary to prevent serious threat to your health or safety or that of others.

PUBLIC HEALTH RESPONSIBILITIES: We will disclose health care information to report problems with products, reactions to medications, disease/infection exposure and to prevent and control disease, injury and /or disability.

MARKETING: We will not use your health information for marketing purposes without your written authorization.

COMMUNICATION BARRIERS: We may use or disclose your health information without consent if, due to significant communication barrier or inability to communicate, we have been unable to obtain your consent and we determine, with professional judgement, that your consent to receive treatment is clearly inferred from the circumstances.

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APPOINTMENT REMINDER: This practice may contact you to provide appointment reminders or information about health related services. The following appointment reminders may be used by this practice: a postcard mailed to you at the address provided by you, telephoning your home or work location and leaving a message on your answering machine or with the individual answering the phone or notifications by email using an email address given by you.

SIGN-IN LOG: This practice maintains a sign in log for individuals seeking care and treatment in the office, This log is in a position where staff can readily see who is seeking care in the office. This information may be seen by, and is accessible to others who are seeking care or services in the Practice's office.

YOUR PRIVACY RIGHTS AS OUR PATIENT:

ACCESS: You have the right to inspect and obtain a copy of your health information (and that health information of an individual fo whom you are legal guardian: as provided by law. To do so, you will need to make your request in writing to the Practices Privacy Officer. If you want the copies to be mailed to you, postage may be charged.

AMENDMENT: You have the right to amend your health information as required by law. To requesting amendment, you must submit a written request to the Practices Privacy Officer; you must provide a reason that supports your request. The practice ay deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the Practice, if the information is not part of your health information maintained by this Practice, or if the information to be amended is already complete and accurate. If you disagree with the Practice's denial, you have the right to submit a written statement of disagreement.

NONROUTINE DISCLOSURES: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make your routine disclosure of your information to professionals for treatment and/or payment purposes, we do not keep a record of disclosures). You can request this information going back six years.

RESTRICTIONS: You have the right to request that we place additional restrictions on our use or disclosures of your health information. However, the practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the Practices Privacy Officer. In your written request, you must inform us of what information you want to limit, and to whom you want the limits to apply If the practices agrees to your request, the practice will comply unless the information is needed to order to provide you with emergency treatment.

QUESTIONS/COMPLAINTS: You have the right to file a complaint with us if you feel your privacy rights have been violated. Your compliant must be directed in writing to our Privacy Officer. You also have the right to complain to the Office of Civil Rights, U.S Department of Health and Human Services, 200Independence Avenue SE, Room 509F, HHH Building, Washington D.C. 20201 202/61 9/0257 or to the Florida Attorney General, Office of the Attorney General, PL-01 The Capital, Tallahassee, FL 32399 850/414/3300. WE support your right to the privacy of your information and would not retaliate in anyway if you chose to file a complaint.

PLEASE LIST THOSE YOU WANT TO HAVE ACCESS TO YOUR PERTINENT MEDICAL INFORMATION:
Anyone who would be allowed to call our office and ask questions regarding your records. (Example; parents, children and/or spouses)

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I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them. I understand this Notice. I understand that this Notice will be placed in my patient chart and maintain for six years.

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Patient/ Guardian Name (please print) Date

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Patient/ Guardian Signature