

# DOLORA PAIN MANAGEMENT ASSOCIATES, P.C.

12434 E. 12 Mile Road,#203, Warren, MI 48093

Tel:586-755-4333

Fax:586-755-4744



## NOTICE OF PRIVACY PRACTICES

### TO OUR PATIENTS:

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by this Practice in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared the explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: Treatment, Payment and Health care operations:

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing, or collection activities, utilization review. An example of this we be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspect of running or practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example of this would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified to you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means of at alternative locations.
- The right to inspect and copy your protected health information (our normal copying fee will be required)
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice form us upon request.

### PATIENT ACKNOWLEDGEMENT

I have received, read and understand your Notice of Privacy Practices containing a complete description of the uses and disclosures of my health information. I understand that this Medical Practice has the right to change its Notice of Privacy Practices from time to time and that I may contact the office at any time to address noted in this notice to obtain a copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

**Commitment to chronic and cancer pain management.**  
**Website: [www.dolorapain.com](http://www.dolorapain.com)**