NOTICE OF PRIVACY PRACTICES

PHILLIP KISSEL, M.D.
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SAN LUIS OBISPO, CA. 93401

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This Notice describes how health information about you (as a patient of Phillip Kissel, M.D.) may be used and disclosed, and how you can get access to your protected health information.

Please review this notice carefully.

A. Our Commitment to your privacy

Our practice is dedicated to maintaining the privacy of your protected health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI
- Your privacy rights in your PHI
- Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your future records that we may create or maintain in the future. You may request a copy of our most current Notice at any time.

B. We may use and disclose your protected Health Information (PHI) in the following ways

The following categories describes the different ways in which we may use and disclose your PHI

1. TREATMENT: Our practice may use your PHI to treat you. For example, we may ask you to have diagnostic test (such as MRI or myelogram), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Some of the people who work for our practice- including, but not limited to, our doctor, office staff and transcriptionist-may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.
2. PAYMENT: Our practice may and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.
3. HEALTH CARE OPERATIONS. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.
4. APPOINTMENT REMINDERS. Our practice may use and disclose your PHI to contact you and remind you of an appointment.
5. TREATMENT OPTIONS. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.
6. HEALTH-RELATED BENEFITS AND SERVICES. Our practice may use and disclose you PHI to inform you of health-related benefits or services that may be of interest to you.
7. RELEASE OF INFORMATION TO FAMILY/FRIENDS. Our practice may release your PHI to a friend or family member who is involved in you care, or who assists in taking care of you. For example, if a friend brings you to your appointment and you choose for them to come in with you, that person would have access to your medical information.
8. DISCLOSURES REQUIRED BY LAW. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administrations requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164-500.

E. YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding the PHI that we maintain about you:

1. CONFIDENTIAL COMMUNICATIONS. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to Practice Manager, 699 California Blvd., Suite A, San Luis Obispo, Ca. 93401 specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.
2. REQUESTING RESTRICTIONS. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of you PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are NOT required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of you PHI, you must make your request in writing to the office. Your request must describe in a clear and concise fashion:
   a) the information you wish restricted
   b) whether you are requesting to limit our practice's use, disclosure or both: and
   c) to whom you want the limits to apply.
3. INSPECTION AND COPIES. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the office in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.
4. AMENDMENT. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the office. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.
5. ACCOUNTING OF DISCLOSURES. All of our patients have the right to request and "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for non-treatment, non-payment or non-operations purposes. Use of your PHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor, sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain as "accounting of disclosures," you must submit your request in writing to the office. All requests for an "accounting of disclosures" must state a time period, which may not be longer that six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.
6. RIGHT TO A PAPER COPY OF THIS NOTICE. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact the office.
7. RIGHT TO FILE A COMPLAINT. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Dept. of Health and Human Services. To file a complaint with our practice, contact the office. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
8. RIGHT TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DISCLOSURES. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke you authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note we are required to retain records of your care for 7 years.

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Receipt of Notice of Privacy Practices
Written Acknowledgement Form

(Please Check One)

I, ___________________________________, have received a copy of the Notice of Privacy Practices.

I, ____________________________________, refused to accept a copy of the Notice of Privacy Practices.

________________________________ ___________________
Signature of Patient Date