



**LAS VEGAS
RADIOLOGY**
TOMORROW'S RADIOLOGY IMAGING... TODAY

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AS WELL AS, HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS FORM CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your “*protected health information*” (**PHI**) to carry out treatment, payment or health care operations and for other purposes that are permitted or required law. It also describes your rights to access and control your protected health information. PHI is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

Uses and Disclosures of Protected Health Information: Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you to pay your healthcare bills, to support the operation of the physician’s practice and any other use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party. For example, we would disclose your PHI, if necessary, to a home health agency that provides care you or to a physician to whom you were referred to, to ensure that the physician has the proper information to treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your healthcare services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your physician’s practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, if necessary, to contact you to remind you or your appointment.

We may use or disclose your PHI 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 administration requirements: legal proceedings: law enforcement: coroners, funeral directors and organ donation: research: criminal activity: military activity and national security: worker’s 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.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization at any time in writing, except to the extent that your physician or the physician’s practice has taken action in reliance on the use or disclosure indicated in the authorization.

Your Rights: To following is a statement of your rights with respect to your PHI.

You have the right to inspect and copy your PHI: This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.



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Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit, use and disclose your PHI then the information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us upon request, even if you have agreed to accept this notice alternatively, ie electronically.

You may have the right to have your physician amend your PHI: If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive and accounting of certain disclosures we have made, if any, of your PHI. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object of withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on or before April 14, 2003.

We are required by law to maintain the privacy of and provide individuals with, this notice of our legal duties and privacy practices with respect to PHI. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices

Print Name _____ Signature _____ Date _____