PAIN SPECIALISTS OF TX, 1759 Broad Park Cir S, STE 101, Mansfield, TX 76063, Phone: 682-518-0682

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

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

Our Privacy Pledge

We want you to understand that we respect your privacy. Other than the necessary uses and disclosures we described below, we will not sell your health information or provide any of your health information to any outside marketing company.

Uses and Disclosures

Here you will find examples of how we may have to use or disclose your health care information:

1. Your physician or a staff member may have to disclose your health information (up to and including all of your clinical records) to another health care provider or a hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition.
2. It may be necessary for our insurance and/or billing staff to disclose your examination and treatment records and your billing records to another party, such as an insurance carrier, your employer, a family member, other relative or close personal friend, who is involved in your care or to facilitate the payment related to your care.
3. It may be necessary for the physician and members of the staff to use your health information, examination, and treatment records and your billing records for quality control purposes or for other administrative purposes to efficiently and effectively run our practice.
4. Your physician and members of the practice staff may need to use your information (ex. name, address, phone number, and your clinical records) to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If you are not at home to receive an appointment reminder, a message will be left on your answering machine.

As our patient, you have the right to refuse to give us the authority to contact you regarding the above-mentioned circumstances. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care. You may inspect or copy the information that we use to contact you.

Permitted uses and disclosures without your consent or authorization

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in these following circumstances:

1. If we are providing services to you based on the orders of another health care provider.
2. If we provide health care services to you in an emergency or disaster relief situation.
3. If we are required by law to treat you and we are unable to obtain your consent after attempting to do so.
4. If we provide health care services to you as a result of a Workers' Comp injury.
5. If you are/ were a member of the armed forces, we are required by military command authorities to release your health information.

6. If we provide health care services to you as an inmate.
7. If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.

Other than the circumstances described in the above examples, any other use or disclosure of your health information will only be made with your written consent.

Your right to revoke your authorization

You may revoke (take away) your privacy release authorization from us at any time; however, your revocation must be in writing. You can call for information about revoking your authorization during normal business hours, or send your request to the address listed below. There are two circumstances under which we will not be able to honor your revocation request.

1. If we have already released your health information before we received your request to revoke your authorization. 164.508(b)(5)(i).
2. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

If you wish to revoke your authorization, please write to us at:

Pain Specialists of Texas
1759 Broad Park Circle South, Suite #101, Mansfield, Texas 76063

Your right to limit uses or disclosures

If there are health care providers, hospitals, employers, insurers or other individuals or organizations to whom you do not want us to disclose your health information, please let us know, in writing, what individuals or organizations to whom you do not want us to disclose your health care information. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us. If we do not agree to your restrictions, you may drop your request or you are free to seek care form another health care provider.

Your right to receive confidential communication regarding your health information

We normally provide information about your health to you in person at the time you receive services from us. We may also mail you information regarding your health or about the status of your account. We will do our best to accommodate any reasonable request if you would like to receive information in a different form. To help us respond to your needs, please make any request in writing.

Your right to inspect and copy your health information

You have the right to inspect and/or copy your health information for seven years from the date the record was created or as long as the information remains in our files. We require your request to inspect and/or copy your health information be in writing.

Your right to amend your health information

You have the right to request that we amend your health information for seven years from the date the record was created or as long as the information remains in our files. We require your request to amend your records to be in writing and for you to give us a reason to support the change you are requesting us to make.

Your right to receive an accounting of the disclosures we have made of your records

You have the right to request that we give you an accounting of the disclosures we have made of your health information for the last six years before the date of your request. The accounting will include all disclosures except:

- Those disclosures required for your treatment, to obtain payment for your services or to run our practice.
- Those disclosures made to you.
- Those disclosures necessary to maintain a directory of the individuals in our facility or to individuals involved in your care.
- Those disclosures made for national security or intelligence purposes.
- Those disclosures made to correctional officers or law enforcement officers.
- Those disclosures that were made prior to the effective date of the HIPPA privacy law.

Our Duties

We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information. We must abide by the terms of this notice while it is in effect. However, we reserve the right to change the terms of our privacy notices. If we make a change in our privacy terms the change will apply for all of our health information in our files.

Redisclosure

Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

For more information or to report a problem

If you have questions and would like additional information, you may contact our practice's Chief Privacy Officer, Lynne George, at **(682) 518-0682,** or in writing to the
Chief Privacy Officer at
1759 Broad Park Circle South, Suite #101, Mansfield, Texas 76063.

If you believe your privacy rights have been violated, you can either file a complaint with this office or with the Office for Civil Rights, U.S. Department of Health and Human Services (OCR). There will be no retaliation for filing a complaint.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I understand I may receive a paper copy with this authorization at my request. This notice is effective as of 4/09/11. This authorization will expire seven years after the date in which you last received services form us.

Signature _____ Date ____/____/20___

Witness _____ Date ____/____/20___