

RAJEEV SEHGAL, DPM, FACFAS

PATIENT PRIVACY NOTICE

EFFECTIVE DATE: 04-14-2003

WHO WILL FOLLOW THIS NOTICE

This notice describes our practice's patient privacy policies involving any health care professional, employee, staff and/or other authorized individual in this practice.

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive in our practice. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by our practice. It will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- Make sure that medical information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose medical information. For each category of uses and disclosures we will explain what we mean.

- For treatment. We may use medical information about you to provide you with medical treatment of services. We may disclose medical information about you to doctors, nurses, assistants, technicians, or other practice personnel who are involved in taking care of you.
- For Payment. We may use and disclose medical information about you so that the treatment and services you receive in our practice may be billed to and payment may be collected from you, an insurance company, or a third party.
- For General Practice Operations. We may use and disclose medical information about you for the general practice operations necessary to make sure all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you.
- Appointment Reminders. We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at our office.
- Treatment Alternatives. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.
- Health-Related Benefits and Services. We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.
- Individuals Involved in Your Care or Payment for Your Care. We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care.
- Research. Under certain circumstances, we may use and disclose medical information about you for research purposes. All research projects, however, are subject to a special approval process. You will never be identified in any research project without your expressed prior authorization.
- As Required By Law. We will disclose medical information about you when required to do so by federal, state, or local law.
- To Avert A Serious Threat to Health or Safety. We may use or disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

SPECIAL SITUATIONS

- Military and Veterans. If you are a member of the armed forces, we may release information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate military authority.
- Workers' Compensation. We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

RAJEEV SEHGAL, DPM, FACFAS

- Public Health Risks. We may disclose medical information about you for public health activities. These activities generally include the following:
 - o To prevent or control disease, injury or disability;
 - o To report births and deaths;
 - o To report child abuse or neglect;
 - o To report reactions to medications or problems with products;
 - o To notify people of recalls of products they may be using;
 - o To notify people who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
 - o To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required by law.
- Health Oversight Activities. We may disclose medical information to a health oversight agent for activities authorized by law. These oversight activities include, for example, audits, investigation, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights.
- Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- Law Enforcement. We may release medical information if asked to do so by a law enforcement official.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information we maintain about you.

- Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records.
 - To inspect and copy medical information that must be used to make decisions about you, you must submit your request in writing. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request.
- Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the practice.
 - o To request an amendment, your request must be in writing. In addition, you must provide a reason that supports your request.
 - o We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
 - Was not created by use, unless the person or entity that created the information is no longer available to make the amendment;
 - Is not part of the medical information kept by or for the practice;
 - Is not part of the information which you would be permitted to inspect and copy; or is inaccurate or incomplete.
- Right to an Accounting of Disclosures. You have the right to request in writing an “accounting of disclosure”. This is a list of the disclosures we made of medical information about you.
- Right to Request Restrictions. You have the right to request in writing a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.
 - o We are not required to agree to your request.
 - o To request restrictions, you must make your request in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example disclosures to your spouse.
 - o To request confidential communication, you must make your request in writing if related to payment or billing information. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

RAJEEV SEHGAL, DPM, FACFAS

- Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the office. The notice will contain the effective date on the first page.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, you may find out the procedure by asking any practice doctor or staff member. Complaints must be submitted in writing. You will not be penalized for filing a complaint.

OTHERS USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provide you.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

Name of Individual (Please print)

Signature of Individual

Signature of Legal Representative
(Attorney, guardian, parent if patient is a child)

Relationship

Date Signed

Witness