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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED
PLEASE READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your Protected Health Information ("PHI"), Individually Identifiable Health Information (IIHI) is used. HIPAA provides penalties for covered entities that misuse personal health information.

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/ IIHI, your privacy rights in your PHI/IIHI, our obligations concerning the use and disclosure of your PHI/IIHIAs required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information. This notice is effective as of September 01, 2013 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to revise and amend the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI/IIHI that we maintain. We will post a copy and you may request a written copy of the revised Notice of Privacy Practice from our office. Any revision or amendments 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 records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation, and law enforcement.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your healthcare and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to conduct certain business and operational activities. These activities include, but are not limited to, quality assessment activities, employee review activities, arranging and/or conducting other business activities.

For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when the doctor is ready to see you. We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

Payment: Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery. If you have paid for services "out of pocket", in full and in advance, and you request that we not disclose PHI/IIHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual. However, we shall do our best to assure its continued confidentiality to the extent possible.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, or investigations. Oversight agencies seeking this information may include government agencies that oversee the health care system, government benefit programs, and other government regulatory programs and civil rights laws.

Unless you object, we may disclose to a member of your family, or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you.

Print Name: _____ Signature:_____ Date:_____

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You may have the following rights with respect to your PHI/IIHI:

- The right to request restrictions on certain uses and disclosures of PHI/IIHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the 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 by alternative means or at alternative locations.
- The right to inspect and copy your PHI/IIHI.
- The right to amend your PHI/IIHI.
- The right to receive an accounting of disclosures of your PHI/IIHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI/IIHI is intentionally or unintentionally disclosed.

You have recourse if you feel that your protection has been violated by our office. You have the right to file a formal, written complaint with the practice and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer (Cynthia Wiley @ 405-278-7911 Ext. 306) for more information, in person or in writing.

You may revoke any/all 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 prior authorization.

By signing this form, I am consenting that I am a patient (or guarantor to patient) of Dr. Clarence L. Wiley, Sr., and I also hereby acknowledge receipt of Notice of Privacy Practices. I consent to BTHD's use and disclosure of my PHI/IIHI to carry out treatment, payment, and healthcare operations. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, BTHD may decline to provide treatment for intended individual.

Name [please print]: _____

Signature: _____

Date: _____

OR

I am a parent or legal guardian of _____ [patient name]. I hereby acknowledge receipt of Beauty thru Health Dermatology's Notice of Privacy Practices with respect to the patient.

Name [please print]: _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____

Date: _____

Office Use Only:

_____
Signature

Date:_____