A-All Women Care 7908 West Sahara Avenue, Las Vegas, NV 89117 702-531-5400

NOTICE OF PRIVACY PRACTICE

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, be kept properly confidential. This Act gives you, the patient significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entities that misuse personal health information.

As required by "HIPPA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes:

- Treatment: means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would be a physical examination or tests done by one physician and requested copies by another treating physician.

- Payment: means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment. Another example will be to dispute a bill for services rendered by your insurance agency or by your credit card company

- Health care operations: include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such 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 authorizations.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you.
- We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications for protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of __________________________, 20____ and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office.

Please contact us for more information, or you can contact the Health Department.
For more information about HIPPA or to file a complaint:

U.S. Department of Health & Human Services Offices of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
Phone: 1-202-619-0257
Toll Free: 1-877-696-6775

By signing below, you acknowledge the document above giving us permission to share your medical information with the agencies, medical offices, insurance providers and financial institutions so as to provide better care for you and so as to resolve financial disputes that may arise from your medical care in our office.

______________________________ ______________________

Patient Signature Date

I , ______________________________ give Anna Contomitros, M.D. of A-All Women Care and Woman to Woman Gynecology, the authorization to release and discuss any information about myself to the following people:

◯ No one

◯ __________________________ _______________________

Name Relation to Patient

I understand that it is my full responsibility to notify the office of any changes.

______________________________ ______________________

Patient Signature Date