



HIPAA COMPLIANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of protected health information has been identified as a national problem causing some patients inconvenience, aggravation and money. We want you to know that all of our employees/managers periodically receive training to assist them in understanding and complying with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with a particular emphasis on the "Privacy Rule". We strive to achieve the highest standards of ethics and integrity in performing services for our patients.

When it is appropriate and necessary we provide the minimum necessary information to only those that we feel are in need of your health care information. Other entities may have indirect treatment relationships with you and we may have to disclose personal health information for purposes of treatment or payment. These entities are often not required to obtain patient consent. You may refuse, in writing, the consent to the use or disclosure of your personal health information. Under this law, we then have the right to refuse to treat you should you refuse to disclose your personal health information. At any time in the future, you may request to refuse full or partial disclosure of your personal health information. However, you may not revoke actions that have already been taken based upon this or previously signed consents.

It is our policy to determine appropriate uses of personal health information in accordance with the governmental rules, laws and regulations. We want to ensure that our Center never contributes in any way to the growing problem of improper disclosure of personal health information. We have implemented a program we believe will help us prevent any inappropriate use of personal health information.

We also recognize that no system is perfect! So it is also our policy to listen to our patients and employees without any thought of penalty if they feel that an event in any way compromises our policy of integrity. We welcome your input regarding any service problem so we may remedy the situation promptly.

This consent allows us to notify you by all means of communication including: mail, phone, fax, e-mail. As our patient you will be placed on our mailing list. Please notify us if you prefer to not receive our newsletter or other mailings. Also please notify us if you have any special requests regarding how we contact you – if none are requested we may leave messages at your given phone number or on an answering machine.

I acknowledge I have received a copy of Suncoast Hearing Services Plus, Notice of Privacy Practices. If you have any questions please ask to speak to our Privacy Officer.

Thank you for being one of our highly valued patients.

Signature of Patient or Authorized Person

Date