NEW MEXICO PAIN ASSOCIATES

8300 Carmel Ave NE Bldg. 5
Albuquerque, NM 87122
(505) 633-4141

Notice of Health Information Privacy Practice (HIPAA)

HIPAA Notice of Privacy Practices

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.

This Notice of Privacy Practices explains how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information (PHI)" is information about you, including demographic information, that may identify you and relates to your past, present, or future physical or mental health or condition and related health care services.

1. Uses and Disclosure of Protected Health Information

Your Protected Health Information may be used and disclosed by your physician, our office staff and others outside our office that are involved in your care and treatment for the purpose of providing healthcare services to you, to pay your healthcare bills, to support the operation of the physician's practice and any other use required by law.

Treatment: We will use and disclose our protected health information to provide, coordinate, or manage health care and any related services. This includes the coordination or management of your healthcare with a third party. For example, we would disclose your protected health information as necessary, to a home health agency that provides care for 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 to treat you.

Payment: Your protected health information will be used, as needed to obtain payment for your healthcare services. For example awaiting approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use to disclose, as needed, your protected health information in order to support the business activities of your physician's practices. These activities include, but not limited too, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other business. For example, we may disclose your protected health information to medical school students that see and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information as necessary to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Neglect Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, Organ Donations Research, Criminal Activity, Military Activity, National Security Workers Compensation and Inmates Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization, and opportunity to object unless required by the law.

You may revoke this authorization any time in writing except to the extent that your physician or the physician's practices had taken an action in reliance on the use or disclosure.

2. Your Rights

The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information: Under the federal law you may not inspect or copy the following records: psychotherapy notes information compiled in reasonable anticipation of or use in a civil criminal, or administrative action, or proceeding and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction: This means you may ask us not to disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members who may be involved in your care or for notification purposes a described in the Notice of Privacy Practices. Your request must state the specific restriction and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use of your protected health information, disclosure of your information will not be restricted. You then have the right to use another healthcare professional.

You have the right to request to receive confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to request your physician to amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you a copy of such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint**. We will not retaliate against you for filing a complaint**.

This notice was published and becomes effective on or before **March 03, 2016.**

I have carefully read and understand the above, and do herein expressly and voluntarily authorize the disclosure of the above information about, or medical records of,

_____, to those persons or agencies listed above.

Patient or Patient Representative

Date: _____

_____

Patient or Patient Representative **Signature**

_____

Name of Patient's Representative **Print Name**

Relationship _____