Dover Audiology
Let the conversation begin

HIPPA COMPLIANCE NOTICE

RIGHT TO NOTICE AS A PATIENT: You have the right to adequate notice of the uses and disclosures of your protected health information. Under the Health Insurance Portability and Accessibility Act (HIPPA), Dover Audiology, P.A., can use your protected information for treatment, payment and health care operations.

a) TREATMENT: We may use or disclose your health information to a physician or other health care providing treatment to you. **b) PAYMENT:** We may use and disclose your health information to obtain payment for services we provide to you. **c) HEALTH CARE OPERATION:** Health care operations include quality assessment and improvement activities, review the competency or qualification of healthcare professionals, evaluation provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

YOUR AUTHORIZATION: Most uses and disclosures that do not fall under treatment, payment, health care operations will require written authorization. Upon signing, you may revoke your authorization in writing through our practice at any time.

EMERGENCY SITUATIONS: In the event of your incapacity or an emergency situation, we will disclose health information to a family member, or another person responsible for your care, using our professional discretion. We will only disclose health information that is directly relevant to the person's involvement in your health care.

MARKETING: We will not use your health care information for marketing communication without your written authorization.

REQUIRED BY LAW: We may also use or disclose your health care information when we are required by law.

ABUSE OR NEGLECT: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the victim of other crimes. You may disclose your health information to the extent necessary to avert a serious threat to you or other people's health or safety.

NATIONAL SECURITY: We may disclose your health information of armed forces personnel to military authorities under certain circumstances. We may disclose health information to authorized federal officials required for lawful intelligence, counterintelligence and other national security activities. We may disclose health information of inmates to the appropriate authorities under certain circumstances.

APPOINTMENT REMINDERS: We may use or disclose your health information to provide you reminders via phone, email or letter.

YOUR RIGHTS AS A PATIENT: You have the right to restrict the disclosure of your protected health information (in writing). The request for restriction may be denied if the information is required for treatment, payment or health care operations. You have the right to receive confidential communications regarding your protected health information. You have the right to inspect and copy your protected health care information. You have the right to amend your protected health information. You have the right to a paper copy of this notice of privacy.

LEGAL REQUIREMENTS: Dover Audiology, P.A. is required by law to maintain the privacy of your protected health information. We are required to abide by the terms of this notice as is currently stated, and reserve the right to change this notice. The policies in any new notice will not be in effect until they have posted within our office.

COMPLAINTS: If you have any complaints regarding the way your protected health information has been handled, you may submit a complaint in writing to our office. You will not be retaliated against in any manner for a complaint. For further information about Dover Audiology, P.A. sprivacy policies, please contact Chris Clukey at 859 West Main Street, Dover-Foxcroft, Maine 04426 or call 207-654-3337.

I have received and read the privacy practices of Dover Audiology, P.A.

I give permission to Dover Audiology, P.A. to send information to me through the mail, leave a message on my answering machine with me and/or my spouse or those within the contact household.

Please check one: I do _____ I do not _____ wish to have a copy of this HIPPA Compliance Notice.

Signature of patient or guardian:_____ Date: _____