SAH
ORTHOPAEDIC
ASSOCIATES
INSTITUTE FOR JOINT RESTORATION

HIPAA NOTICE OF PRIVACY PRACTICES NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS CAREFULLY.

This Notice of Privacy Practices describes 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 that relates to your past, present or future physical or mental health or condition, and health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)
Your PHI may be used and disclosed by your physician, our office and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your PHI may be provided to a physician to whom you have been referred to ensure that physician has the necessary information to diagnose or treat you
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Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for a hospital stay or admission.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training programs, licensing, and conducting or arranging for 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 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 PHI, as necessary, to contact you to remind you of your appointment.

We may use or disclose your PHI in the following situations without your authorization as required by law: Public Health issues, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal proceedings, Law Enforcement, Coroners, Funeral Directors, Organ Donations, Research, Criminal Activity, Military Activity and

National Security, Workers Compensation, 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 requirements of Section 164.0500.

Other permitted required uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You make revoke this authorization at any time in writing except to the extent that your physician or physicians practice has taken action in reliance on the use or disclosure indicated in the authorization.

I acknowledge that I have been informed and reviewed a hard copy of the Privacy Notice.

______________________________________ _____________
Patient Signature Date

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Print Patient Name

The above named patient is unable to sign and authorizes his/her personal representative to sign on his/her behalf.

______________________________________ _____________
Personal Representative Signature Date

______________________________________ _________________________
Print Name of Personal Representative Relationship to Patient

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Health Information Release

Due to HIPAA restrictions our office is unable to release any information about a patient without a signed document indicating whom we may release information to (i.e. family member, friend, etc.) Information released can include, but is not limited to: appointments, lab results, insurance/billing, etc.)

I authorize, Sah Orthopaedic Associates, to disclose my health information to:

______________________________	______________________________
Name	Relationship to Patient
______________________________	______________________________
Name	Relationship to Patient
______________________________	______________________________
Name	Relationship to Patient

Telehealth Services

Any phone calls regarding clinical assessment or advice will be documented in your medical record and therefore may generate a telehealth fee to your insurance company. These services are available to provide you the best and most convenient service possible, in accordance with HIPAA guidelines in an effort to protect your PHI.

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Patient Signature