

Joe Ellis Wheeler, M.D., P.A.
750 8th Avenue, Suite 530
Fort Worth, TX 76104
(817) 335-3966 Office
(817) 335-7926 Facsimile

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.

This practice uses and discloses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. This notice describes our privacy practices. You can request a copy of this notice at any time. For more information about this notice or our privacy and policies, please contact the Office Manager.

Treatment, Payment, Health Care Operations

Treatment

We are permitted to use and disclose your medical information to those involved in your treatment. We may request that your primary care physician share your medical information with us. Also, we may provide your primary care physician information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any.

Payment

We are permitted to use and disclose your medical information to bill and collect payment for the services provided to you, that your insurer or HMO/PPO needs to approve payment to us.

Health Care Operations

We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered.

Disclosures That Can Be Made Without Your Authorization

There are situations in which we are permitted by law to disclose or use your medical information without your written authorization or an opportunity to object. If you object to this company disclosing information about you, we must be notified in writing.

Public Health Abuse or Neglect, and Health Oversight

We may disclose your information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (like death certificates), or injury by a public health authority. We may disclose medical information if authorized by law, to a person who may have been exposed to a disease or may be at risk for contacting or spreading a disease or condition. We may disclose your medical information to report reactions to medications, problems with products, or to notify people of recalls of products that we may be using.

Texas law also requires physicians to report child abuse or neglect. Regulations also permit the disclosure of information to report abuse or neglect of elders or the disabled.

We may disclose your medical information to a health oversight agency for those activities authorized by law.

Legal Proceedings and Law Enforcement

We may disclose your medical information in the course of judicial or administrative proceedings in response to an order of the court (or the administrative decision maker) or the other appropriate legal process. Certain requirements must be met before the information is disclosed.

We will release if:

- : Warrant or Subpoena
- : If you were the victim of a crime, and you are incapacitated.
- : If it pertains to a person who has died under circumstances that may be related to criminal conduct.
- : If it is about a victim of crime and we are unable to obtain the persons agreement.
- : If it was due to a crime that occurred on these premises.
- : If it is being used to locate a fugitive, missing person, or suspect.

We may also release information if we believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.

Workers Compensation

We may disclose your information as required by the Texas Workers' compensation law.

Required by Law

We may release your medical information where the disclosure is required by law.

Your Rights Under Federal Privacy Regulations

The United States Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against a patient that exercises their HIPAA rights.

Requested Restrictions

You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or healthcare operations. We **do NOT** have to agree to these restrictions, but if we do agree, we will comply with your request except under emergency circumstances or court order.

To request a restriction, it must be done in writing, and must include what is to be disclosed and to whom we are to disclose the information to.

Amendment of Medical Information

You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to the Office Manager. We will respond within 60 days of your request. We may refuse to allow an amendment if the doctor or healthcare provider feels the information was correct and complete.

If an amendment is made, all healthcare providers and others whom received the original record will be forwarded a copy of the amended record.

Appointment Reminders, Treatment Alternatives, and Other Health Related Benefits

We may contact you by phone, fax, e-mail, or all three to provide appointment reminders, information about treatment alternatives, or other health related benefits and services that may be of interest to you. You will only be contacted by e-mail if you have e-mailed us and asked for a response. If we fax any information at all, the fax number if verified and a cover sheet is always used stating disclosure laws.

Complaints

If you feel your privacy rights have been violated, you may contact the Office Manager.

You may also send a written complaint to The United States Department of Health and Human Services.

Their address is:

U.S. Department of Health and Human Services

HIPAA Complaint

7500 Security Blvd., C5-24-04

Baltimore, MD 21244

Questions and Contact Person for Complaints or Requests

Karen Williams, CPC, CMOM

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(817) 335-3966 Office

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Whelearnsl@aol.com E-mail

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Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient or Personal Representative

Date

Printed Name of Patient or Personal Representative

Description of Personal Representatives Authority

Witness to Signature

Date