CONCIERGE CARPAL TUNNEL and HAND SURGERY

HIPAA Notice of Privacy Practices

1. Policy regarding confidentiality of all forms of Patient Records. All PHI regardless of its form, mechanism of transmission, or storage is to be kept confidential. Only individuals with a business need to know are allowed to view, read, or discuss any part of a patient's PHI. During initial new hire orientation and at annual HIPAA training employees are reminded that any viewing, reading, or discussions of PHI that is not for business purposes is prohibited. An employee who violates this confidentiality policy will be subject to sanctions up to immediate termination. All employees are required to verify in writing that they have read and will comply with our policy regarding confidentiality of all forms of PHI.

2. All PHI transmitted to third parties will be transmitted on secured lines. The security of transmission lines will be verified via contract with third party responsible for transmitting our patient's PHI. A signed medical records release is necessary for any medical records requests.

3. No digitally stored PHI shall leave this facility.

4. Policy regarding charges for e-copies of medical records. The Privacy Rule permits the Covered Entity (Concierge Carpal Tunnel and Hand Surgery) to impose reasonable, cost-based fees for paper copies. The fee for copies is .60 cents per page.

5. Document Retention Policy: All HIPAA documentation such as policy and procedures, risk assessment, incident investigation, breach notification, and training records will be maintained for at least six years.

Patient Name: _____

Date of Birth: _____

I have received and understand this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices and to make changes regarding all protected health information, resident at, or controlled by this practice. If changes to the policy occur, this practice will provide me a revised Notice of the Privacy Practices upon Request.

Signature: _____

Date: _____

Relationship to patient (If signed by representative of patient): _____