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.

Our Uses and Disclosure

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law

We can use your health information in the following ways:

◦ Share your information with other professionals who are treating you ◦ Run our practice ◦ Improve your care
◦ Contact you when necessary ◦Bill and get payment from health plans and other entities.

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you.

Ask us to amend your medical record

- You can ask us to amend health information about you that you think is incorrect or incomplete.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will ensure that the person has authority before we take any actions.

For certain health information, you can tell us your choices about what we share. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation.

If you are not able to tell us your preference, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

How else can we share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research.

We can share health information about you in certain situations such as: ◦Preventing disease ◦Doing research ◦Helping product recall ◦Preventing or reducing serious threats to anyone's health or safety ◦Reporting suspected abuse, neglect, or domestic violence ◦Reporting adverse reactions to medications

We will share information about you if state or federal laws require it. We can share information about you: ◦For workers' compensation claims ◦For law enforcement purposes or with a law enforcement official ◦With health oversight agencies for activities authorized by law ◦ For special government functions as military, national security, and presidential protective services ◦Respond to lawsuits and legal actions

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. This new notice will be available upon request in our office.

You Have A Right To File A Compliant If You Feel Your Privacy Has Been Violated

If you feel your Privacy Rights have been violated, please ask your staff for a Privacy Complaint Form. Our Security Officer will review the form and promptly notify you of the actions our office will take.

John R Oliver, M.D., PC Phone: 907-357-6121

This Notice of Privacy Practices is effective November 15, 2018

PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

I hereby consent to the use or disclosure of my Protected Health Information by Dr. John Oliver, in order to carry out treatment, payment and/or coordination of care with other providers.

At all times, I retain the right to revoke this consent. Such revocation must be submitted to Dr. Oliver, in writing. The revocation shall be effective except in those instances that occurred prior to the revocation.

I have read and understand this information. I am the patient or the individual authorized to act on behalf of the patient to sign this document verifying consent to the above stated terms.

______________________________ **Patient Name (Please Print)**

______________________________ **Signature and Date**
(If you are signing for the patient, list your relationship to the patient)

Consent to Disclose Health Information to Family Members and/or Friends

I give permission for my Protected Health Information to be disclosed to the family members and/or others listed below for the purpose of communicating results, findings, and care decisions:

Name: ____________________ Phone number: ______________

Name: ____________________ Phone number: ______________

Name: ____________________ Phone number: ______________

Name: ____________________ Phone number: ______________

Please list the family members or others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY**.

Name: ____________________ Phone number: ______________

Name: ____________________ Phone number: ______________

Name: ____________________ Phone number: ______________

Name: ____________________ Phone number: ______________

Consent for Appointment reminders and other Healthcare Communications

Can we send you text messages about appointments, labs and other healthcare information? ☐Yes ☐ No
The cell phone that I authorize to receive text messages is: ____________________
Our office does not charge for this service but standard text messaging rates may apply (contact your carrier for plans and detail).

Can we email you about appointments, labs and other healthcare information? ☐Yes ☐ No
The email address that I authorize to receive email messages is: ____________________

Can we leave confidential messages on your answering machine or voicemail? ☐Yes ☐ No
Can we contact you at work? ☐Yes ☐ No