

## NOTICES OF PRIVACY PRACTICES SUMMARY

*Precision Aspiration and Biopsy understands that medical information about you and your health is personal; and we are committed to protecting medical information about you. We are required by law to maintain the privacy of certain confidential health care information. This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment or health care operations, and for other purposes that are permitted or required by law.*

### USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

We are permitted to use and disclose medical information in the following general categories:

**Treatment** This includes such things as obtaining verbal and written information about your medical condition and treatment from you as well as from others, such as doctors, medical facilities, or other health care providers involved in your treatment.

**Payment** This includes any activity we must undertake in order to be reimbursed for services we provide to you.

**Health Care Operations** This includes quality assurance activities (i.e. follow up on surgical pathology material), licensing and training programs to ensure that our personnel meet our standards of care and follow established policies and procedures, as well as other management functions.

In most cases, disclosures are made with your consent. There are certain instances in which disclosures may be made without your authorization, many of which are required by law.

### YOUR RIGHTS

In most cases, you have the right to **inspect** or get a **copy** of your health information that we use to make decisions about you. You have a right to **request a restriction** of your PHI. You may also receive an **accounting** of certain disclosures we have made, if any, of your PHI. If you believe that aspects of your health information are incorrect or missing, you have the right to request that we **correct** the existing information. You have the right to request to receive **confidential** communications from us by **alternative means** or alternative locations. You have the right to obtain a **paper copy** of this notice from us.

### PRIVACY COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

### ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

**By signing below, you acknowledge receipt of this Notice of our Privacy Practices.**

**Signature:** \_\_\_\_\_ **Printed Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_