COASTAL NEUROLOGY, P.A.
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Port Royal, SC 29935
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NOTICE OF PRIVACY PRACTICES (HIPAA)

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

Purpose of this Notice
This Notice describes how we may use and disclose your health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. This Notice also outlines our legal duties for protecting the privacy of your health information and explains your rights to have your health information protected. We will create a record of the services we provide you, and this record will include your health information. We maintain this information to ensure that you receive quality care and to meet certain legal requirements related to providing you care. We understand that your health information is personal and we are committed to protecting your privacy and ensuring that your health information is used appropriately.

Our Responsibilities
We are required by law to maintain the privacy of your health information and provide you notice of our legal duties and privacy practices with respect to your health information. We have also appointed a Privacy Officer who is responsible for ensuring that we protect your health information and that we abide by the terms of this Notice.

How We May Use or Disclose Your Health Information
The following categories describe examples of the way we use and disclose health information:

For Treatment: We may use your health information to provide you with medical treatment or services. An example of this would include a physical examination. We may also disclose your health information to another physician or other healthcare providers to be sure those parties have all the information necessary to diagnose and/or treat you.

For Payment: We may use and disclose your health information to others so they will reimburse either party for your treatment. For example a bill may be sent to you, your insurance company or a third-party payer. The bill may contain information tat identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

For Health Care Operations: We may ask you to sign your name to a sign-in sheet, or we may call your name in the waiting room; we may use your name in conversations within the scope of the practice; we may contact you for appointment reminders; we may leave a recorded message for you citing who we are and the purpose in which we are calling. We may disclose your health information to a third party that performs services, such as billing and collections. In these cases we will enter into a written agreement with the third party to ensure they protect the privacy of your health information. We may use and disclose your health information In order to support our business activities. For example, we may use your health information for quality assessment activities, training of students, necessary credentialing and for other essential activities.

Treatment Alternatives and Health-Related Benefits and Services: We may use your health information to inform you of services or programs that we believe would be beneficial to you. We may call, mail or e-mail you information about these services or goods. For example, we may contact you to make you aware of new products, supply product information, or a new patient assistance program that may be available to you.

Other Individuals Involved in Your Care or Payment for Your Care: We may release your health information, including information about your condition, to a family member or friend who is involved in your medical care or who helps pay for your care. **If you would like us to refrain from releasing your health information to a family member or friend, please notify our Privacy Officer or other staff member.** We may also disclose your health information to disaster-relief organizations so that your family or friends can be notified about your condition, status and location.

We are also allowed by to use and disclose your health information without your authorization as required to do so by Federal, State or local law(s).

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are committed to protecting your privacy and ensuring that your health information is used and disclosed appropriately. This Notice of Privacy Practices identifies all potential uses and disclosure of your health information by our practice and outlines your rights with regard to your health information. Please sign the form below to acknowledge that you have received our Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices.

Print Name:_____ Signature:_____

Date:_____ If not the patient, your relationship:_____

Please circle and initial: Would you like a copy of this signed notice? **Yes** **No** _____

Direct inquiries to: The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, DC 20202
(877) 696-6775

For additional questions or concerns, contact Annette Kelley, Office Manager, at 843/522-1420.