This form must be read and signed prior to seeing the doctor, due to new federal guidelines, the Health Insurance Portability and Accountability Act (HIPAA), effective 4-14-03. This Notice of Information describes the terms of how your health information may be used and disclosed by Willoughby Surgery Center, how you can gain access to it and also control who else receives or gains access to this information. At the end of this form, you will be asked to sign an acknowledgement of receipt of this notice, as well as to outline or define specific instances or information that you would like to be restricted from disclosure to other entities or specified individuals.

1. **Willoughby Surgery Center (WSC)** may use and disclose your protected health information for treatment, payment, healthcare operations, and other certain circumstances. These include public health requirements, current laws and court orders, worker's compensation, entities assisting in disaster relief, or other similar programs.
2. **WSC** will not make and other use or disclosure of a patient's protected health information without the individual's written authorization. The patient, at any time, can provide a written statement t revise this authorization.
3. **WSC** may at times contact the patient to provide appointment reminders or information regarding treatment alternatives or other health related benefits and services that may be of interest to the individual patient.
4. **WSC** may release protected health information about you to a friend or family ember who is involved in your medical care, provided that you list these specific people below who we may speak to regarding your medical care
5. **WSC** reserves the right to change the terms of this notice, making new notice provisions effective for all health protected information that it contains. Copies of these changes/revisions will be given to the patient at next visit, or mailed to the last known address if there is a need to disclose any protected health information.
6. Any person may file a complaint to the Practice and to the Department of Health and Human Services, (800-368-1019) Office of Civil Rights, if they believe their privacy rights have been violated. To file a complaint with the practice, please contact the Privacy Officer, Dr. David Demangone, by phone (440) 944-1414, or by mail to Suite 1, 6025 Commerce Circle, Willoughby, OH, 44094. It is **WSC** policy that no retaliatory action will be made individual who submits or conveys a complaint or a suspected or actual non-compliance of the privacy standards.

Patients have been granted individual rights under the HIPAA Legislation, and these include the following:

1. You have the right to inspect and copy protected health information that may be used to make decisions about your care. To inspect and copy your protected health information, you must submit your request in writing to the Privacy Officer listed above. There may be a fee charged to cover the cost of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain circumstances. If so, you may request that the denial be reviewed. A licensed health care professional, but not the one that denied you request, will be chosen by our organization and will review your request and the denial, and make a determination. We will comply with the outcome of the review.
2. If you feel that protected Health Information we have about you is incorrect or incomplete, you have the right to request an amendment for as long as the information is maintained in the designated record set. To do so, your request must be made in writing and submitted to the Privacy Officer. You must provide a reason that supports your request. If not, your request for an amendment may be denied. We may deny your request if you ask us to amend information that was not created by us.
3. You have the right to request an "accounting of disclosures", a list of the disclosures we have made of your protected health information in addition to those for treatment, payment, or health care operations. The request must be in writing and submitted to the Privacy Officer. The request must address two points; (1) a time period not longer than 6 years or earlier than 4-14-03, (2) in what form you want the list (paper, fax, etc). The first list you request with in a 12 month period will be free. There may be a charge, as determined by us, for additional list, at which time you may withdraw or modify your request before nay cost are incurred. The list will be provided to you in under 60 days of your request, unless we utilize a 30 day extension period.
4. You have the right to request a restriction or limitation on the protected health information we disclose about you for a) treatment, payment, or health care operations, b) to someone who is involved in your care or the payment for your care, like a family member or a friend. However, we are not required to agree to your request. To request restrictions, you must make your request in writing to the Privacy Officer, and you must state (1) what information you may want to limit; (2) whether you want to limit our use, disclosure, or both; (3) to whom the limits apply. Either of us may terminate the restriction after notifying the other.

5. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location, such as at work or by mail. You must make a written request to the Privacy Officer including how or where you wish to be contacted. We will not ask you the reason, and we will try to accommodate your request.

Although Willoughby Surgery Center (WSC) will follow the HIPAA guidelines, as stated earlier, regarding use and disclosure of your health information with other entities, you may further restrict the use and disclosure of you information in any manner you wish, acceptable to WSC, by specifying such restrictions below.

(1) I, _____ request the following restrictions to the use or disclosure of my protected health information in the following manner.

_____

_____

_____

_____

If you wish for certain people, other than yourself, to be able to access your health information, the following needs to be completed/described. If you don't complete any further information, then no relatives or friends will be given any information should they request it, other than in an emergency situation.

(2) Willoughby Surgery Center may discuss my medical conditions/information with the following:

(Check)	No	Yes	(If yes, list names)	Name	Relationship
Spouse	O	O	1)		
Parents	O	O			
Children	O	O	2)		
Friends	O	O			
			3)		
If more than 4 names, List additional below.			4)		

Other:_____

_____

_____

_____

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have received and read WSC's Notice of Privacy Practices.

(Patient or their representative signature)_____ Date_____

If signed by patient representative, their relationship to the patient is _____

Office Use Only: In the event that the patient doesn't sign the acknowledgment, our organization has made a good faith effort to obtain a written acknowledgment of receipt of the Notice provided to the individual named below. **(circle one)**

(Patient Name) _____ Refused to sign Physically unable to sign

Specific reasons_____

Employee Signature _____Date_____