AUTHORIZATIONS & CONSENTS

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

This notice describes how medical information may be used, disclosed and accessed. Please review it carefully!

Uses and disclosures of health information: This office is permitted by federal law to make use/disclosure of your health information for treatment, payment and health care operations. Protected health information (PHI) is the information we create and obtain in providing services. This includes documenting symptoms, examination and test results, diagnosis and treatment. It also includes billing for services. Information may be shared verbally, by mail, email, fax, or other methods. Without your authorization, we are prohibited to use or disclose your PHI for marketing purposes and may not sell your PHI without authorization.

We may use or disclose PHI about you without your authorization for several purposes. Subject to certain requirements, we may share PHI for evaluation by our research department, for auditing, for student training, for credentialing, for medical review, for legal services and for insurance. Where applicable, we may disclose PHI to dialysis facilities for dialysis treatment. We also provide information when required by law, such as law enforcement, judicial/administrative proceedings, or public health purposes.

At your request, we may not disclose information about health care you have paid for out-of-pocket to health plans, unless for treatment purposes or in the rare event the disclosure is required by law. We participate in Colorado's Health Information Exchange (HIE) as a means to improve the quality of your health and healthcare experience. The HIE provides us with a way to securely and efficiently share patients' clinical information electronically with other health care providers. The HIE also enables emergency medical personnel and other providers who are treating you to have immediate access to your medical data that may be critical for your care. You may choose to opt-out of participation in the HIE, or cancel an opt-out choice, at any time.

We ask for your written authorization before using or disclosing any PHI. If you chose to sign an authorization, you can later revoke in writing that authorization to stop future uses and disclosures.

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When we make a significant change in our policies, we will change and post the new notice in the waiting area. You can also request a copy of our notice at any time, or download this notice at our website: www.westneph.com. For more information, contact our Compliance Officer listed below.

Your individual rights: You have the right to look at or obtain a copy of your health information. If you request copies, we will charge you copy fees. You also have the right to receive a list of instances where we have disclosed your information for reasons other than treatment, payment, or administrative purposes and other than when you authorized it. If you believe that information in your record is incorrect or missing, you have the right to request that we correct or add the information. We have 30 days to respond to your request. To file a complaint: If you are concerned, we have violated your privacy rights, or if you disagree with a decision we made about access to your records, you may contact the Compliance Officer listed below. You may also send a written complaint to the US Department of Health and Human Services. Our Compliance Officer can provide you with the appropriate address, upon request.

Our legal duties and responsibilities: If a security breach occurs, we are required to notify you within 60 days of discovery. We are required to maintain the privacy of your PHI, provide this notice, follow terms described in this notice, and obtain your acknowledgment of receipt of this notice.

If you have questions or concerns, please contact Western Nephrology Compliance Officer at 4891 Independence St., Suite 120, Wheat Ridge, CO 80033, 303-456-5495.

I hereby acknowledge that I have received Western Nephrology's Notice of Privacy Practices.

Name of Patient: (Print) _____ **DOB** _____

Patient Signature: _____ **Date** _____