TRI-COUNTY GASTROENTEROLOGY, PC

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU, INCLUDING MEDICAL INFORMATION WHICH **TRI-COUNTY GASTROENTEROLOGY, PC** EITHER CREATES OR RECEIVES, IS PROTECTED. THIS INCLUDES MEDICAL INFORMATION RELATING TO YOUR PAST, PRESENT OR FUTURE PHYSICAL OR MENTAL CONDITION. IT ALSO INCLUDES THE TYPE OF HEALTHCARE AND TREATMENT THAT **TRI-COUNTY GASTROENTEROLOGY, PC** MAY BE PROVIDING YOU WITH.

THIS INFORMATION IS KNOWN AS PROTECTED HEATLH INFORMATION. THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION MY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

TRI-COUNTY GASTROENTEROLOGY, PC MAY USE OR DISCLOSE PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS. FOR EXAMPLE, **TRI-COUNTY GASTROENTEROLOGY, PC** MAY PROVIDE YOUR HEALTH INSURANCE COMPANY WITH YOUR PROTECTED HEALTH INFORMATION FOR PAYMENT.

FURTHER, **TRI-COUNTY GASTROENTEROLOGY, PC** MAY USE OR DISCLOSE PROTECTED HEALTH INFORMATION WITHOUT YOUR CONSENT TO OTHER PHYSICIANS, PHARMACIES AND HEALTHCARE PROVIDERS AND PAYORS.

ANY OTHER USES OR DISCLOSURES, OTHER THAN AS DESCRIBED ABOVE, WILL BE MADE ONLY UPON WRITTEN AUTHORIZATION FROM YOU AND THAT AUTHORIZATION MAY BE REVOKED AT ANY TIME IN WRITING EXCEPT TO THE EXTENT **TRI-COUNTY GASTROENTEROLOGY, PC** HAS TAKEN ACTION IN RELIANCE ON THE AUTHORIZATION, OR IF THE AUTHORIZATION WAS OBTAINED AS A CONDITION OF OBTAINING INSURANCE COVERAGE.

TRI-COUNTY GASTROENTEROLOGY, PC MAY CONTACT YOU TO PROVIDE APPOINTMENT REMINDERS OR INFORMATION ABOUT TREATMENT ALTERNATIVES OR OTHER HEALTH REALTED BENEFITS AND SERVICES THAT MAY BE OF INTEREST TO YOU.

YOUR RIGHTS

YOU MAY REQUEST RESTRICTIONS ON CERTAIN USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION, ALTHOUGH **TRI-COUNTY GASTROENTEROLOGY, PC** IS NOT REQUIRED TO AGREE TO THE RESTRICTIONS REQUESTED.

YOU HAVE THE RIGHT TO RECEIVE CONFIDENTIAL COMMUNICATIONS OF PROTECTED HEALTH INFORMATION.

YOU HAVE THE RIGHT TO INSPECT AND COPY PROTECTED HEALTH INFORMATION.

YOU HAVE THE RIGHT TO AMEND PROTECTED HEALTH INFORMATION.

YOU HAVE THE RIGHT TO RECEIVE AN ACCOUNTING OF DISCLOSURES OF PROTECTED HEALTH INFORMATION; AND

YOU HAVE THE RIGHT TO RECEIVE A PAPER COPY OF THE NOTICE FROM **TRI-COUNTY GASTROENTEROLOGY, PC** UPON REQUEST EVEN IF YOU AGREED TO RECEIVE NOTICE ELECTRONICALLY.

Over →

OBLIGATIONS OF TRI-COUNTY GASTROENTEROLOGY, PC

1. **TRI-COUNTY GASTROENTEROLOGY, PC** IS REQUIRED BY LAW TO MAINTAIN THE PRIVACY OF PROTECTED HEALTH INFORMATION AND TO PROVIDE YOU WITH NOTICE OF OUR LEGAL DUTIES AND PRIVACY PRACTICES WITH RESPECT TO PROTECTED HEALTH INFORMATION.

2. **TRI-COUNTY GASTROENTEROLOGY, PC** IS REQUIRED TO ABIDE BY THIS NOTICE OR AS IT MAY BE CHANGED; AND

3. **TRI-COUNTY GASTROENTEROLOGY, PC** RESERVES THE RIGHT TO CHANGE THE TERMS OF ITS NOTICE OF PRIVACY PRACTICES AND TO MAKE THAT CHANGE EFFECTIVE FOR ALL PROTECTED HEALTH INFORMATION THAT **TRI-COUNTY GASTROENTEROLOGY, PC** MAINTAINS.

COMPLAINTS

YOU MAY COMPLAIN TO **TRI-COUNTY GASTROENTEROLOGY, PC** IF YOU BELIEVE YOUR PRIVACY RIGHTS HAVE BEEN VIOLATED.

SAMUEL H. GUN, DO, FACOI WILL RECEIVE WRITTEN COMPLAINTS REGARDING VIOLATIONS OF PRIVACY RIGHTS BY **TRI-COUNTY GASTROENTEROLOGY, PC**, AND NO ACTION WILL BE TAKEN AGAINST YOU FOR FILING A COMPLAINT. COMPLAINTS MAY ALSO BE FILED WITH THE SECRETARY OF HEALTH AND HUMAN SERVICES.

CONTACT

FOR FURTHER INFORMATION REGARDING THIS NOTICE, CONTACT **SAMUEL H. GUN, DO, FACOI**, COMPLIANCE OFFICER, AT (586) 286-5400; 37399 GARFIELD, SUITE 104, CLINTON TOWNSHIP, MI 48036.

EFFECTIVE DATE

THIS NOTICE IS EFFECTIVE APRIL 14, 2003.

IF THERE IS A MATERIAL CHANGE TO THE USES OR DISCLOSURES OF PROTECTED HEALTH INFORMATION, YOUR RIGHTS, LEGAL DUTIES OR OTHER PRIVACY PRACTICES STATED IN OUR "NOTICE OF PRIVACY PRACTICES," **TRI-COUNTY GASTROENTEROLOGY, PC** WILL PROMPTLY REVISE AND DISTRIBUTE ITS "NOTICE OF PRIVACY PRACTICES." NO CHANGE WILL BE IMPLEMENTED PRIOR TO THE EFFECTIVE DATE OF THE NOTICE IN WHICH THE MATERIAL CHANGES APPEAR.

DATE YOU FIRST RECEIVED SERVICES FROM **TRI-COUNTY GASTROENTEROLOGY, PC** AFTER APRIL 14, 2003, IS _____.

To be signed and submitted to office staff.

TRI-COUNTY GASTROENTERLOGY, PC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The undersigned Patient or legally authorized representative ("Agent") of the Patient acknowledges that he or she personally received a copy of the TRI-COUNTY GASTROENTEROLOGY, PC's Notice of Privacy Policies on the date indicated below.

Signature: **X** _____ Date: **X** _____

_____

PATIENT NAME (please print)

Information about Agent (attach appropriate documentation):

Agent: _____

Title: _____

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ☐ The individual refused to sign.
- ☐ A copy was mailed with a request for a signature by return mail.
- ☐ An emergency existed and a signature was not possible at the time.
- ☐ Unable to communicate with the patient for the following reason(s):

  _____

  _____
- ☐ Other:

  _____

  _____

Prepared by: _____

Signature: _____ Date: _____

To be completed and submitted to office staff.

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient: _____ Date of Birth: _____

Tri-County Gastroenterology, PC is authorized to release protected health information about the above-named patient to the entities named below. The purpose is to inform the patient, or others, in keeping with the patient's instructions.

ENTITY TO RECEIVE INFORMATION Check each person/entity that you ✓ approve to receive information.	**DESCRIPTION OF INFORMATION TO BE RELEASED** Check each that can be given to person/entity ✓ on the left in the same section.
_____ Voice Mail	_____ Account information _____ Appointment information _____ Medical information (prescriptions, results, treatment, etc.)
_____ Spouse Spouse's Name:_____	_____ Account information _____ Appointment information _____ Medical information (prescriptions, results, treatment, etc.)
_____ Parent(s) Name: _____ Name: _____	_____ Account information _____ Appointment information _____ Medical information (prescriptions, results, treatment, etc.)
_____ Son / Daughter Name: _____ Name: _____	_____ Account information _____ Appointment information _____ Medical information (prescriptions, results, treatment, etc.)
_____ Other Name: _____ Relationship: _____	_____ Account information _____ Appointment information _____ Medical information (prescriptions, results, treatment, etc.)

Patient Information – I understand that I have the right to revoke this authorization at any time and that I have the right to inspect a copy of the protected health information to be disclosed, as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization shall be in effect until revoked by the patient.

Signature: **X** _____ Date: **X** _____

Signature of PATIENT (or personal representative*)

*If signed by personal representative, please provide description of authority (attach necessary documentation)