OMNI PHYSICAL THERAPY SERVICES

## HIPAA

### Your Right

• Under HIPAA you have the right to request restrictions on certain uses and disclosures of your health and treatment information. Omni Physical therapy services is required to agree to any restrictions that you request, but if it does agree with them, it is bound by that agreement and may not use or disclose any information which you have restricted except as necessary in a medical emergency.

• You have the right to request that we communicate with you by alternative means or at an alternative location (e.g. another address). Omni Physical therapy services will accommodate such requests that are reasonable and will not request an explanation from you.

• Under HIPAA you also have the right to inspect and copy your own health and treatment information maintained by Omni Physical therapy services or information compiled for use in a civil, criminal or administrative proceeding or in other limited circumstances.

• Under HIPAA you also have the right, with some exceptions, to amend health care information maintained in the program's records, and to request and receive an accounting of disclosures of your health related information made by the program during the six (6) years prior to your request.

• If your request to any of the above is denied, you have the right to request a review of the denial by the program Administrator.

• To make any of the above requests, you must fill out the appropriate form that will be provided by Omni Physical therapy services.

• You also have the right to receive a paper copy of this notice. The Use of Your Information In order to provide you with the best care, Omni Physical therapy services will use your health and treatment information in the following ways:

• Communication among staff (including students or other interns) for the purposes of treatment needs, treatment planning, progress reporting and review, staff supervision, incident reporting, medication administration, billing operations, medical record maintenance, discharge planning, and other treatment related processes.

• Communication with Business Associates such as clinical laboratories (blood work, urinalysis), your insurance carrier and other payer source Our Duties

• The program will provide current patients with an updated notice, and will provide affected former patients with new notices when substantive changes are made in the notice.

• We will inform you if we know that an information breach has occurred State of New York Complaints and Reporting Violations Patients have the right to make a complaint about the Confidentiality and Privacy of their Health Information. The patient may complete a Privacy Complaint form and submit the form to the: Office for Civil Rights U.S. Department of Health and Human Services:
Jacob Javits Federal Building, 26 Federal Plaza--Suite 3313, New York, New York, 10278, Voice Phone (212) 264-3313. FAX (212) 264-3039.

• You will not be retaliated against for filing such a complaint. Violation of the Confidentiality law by a program is a crime. Suspected violations of the Confidentiality Law may be reported to the United States Attorney in the district where the violation occurs.

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**PRIVACY POLICY**

Omni Physical Therapy Services is dedicated to keep all of your health information confidential. We keep records in order to provide you with quality care.

1 ) We use your health information ONLY: -

A. For treatment purposes
B. For billing purposes
C. For the operation of the practice
D. As required by law - To avert a serious threat to health, safety
E. To send to military departments as required by law
F. To send to workers' compensation programs
G. To send to law enforcement agencies as required by law

2) Your rights regarding the health information we maintain about you include the rights to:

A. inspect your health information used to make decisions about your care by submitting a written request
B. Amend information that you feel is incorrect by submitting a written request
C. Request a list of accounting of any disclosures of your information not listed above
D. Request a restriction or limitation on health information that we disclose by submitting a written request.

Please ask the staff if you have any further questions regarding your privacy. A more detailed HIPAA notice is available upon request. Please sign below to acknowledge receipt of this notice. IF you are a parent or guardian of a minor and/or a healthcare proxy, please mention your relation in the space assigned.

SIGNATURE: _____ DATE: _____

NAME: _____ RELATION: _____