



West Chester Cardiology
www.westchestercardiology.com

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NOTICE OF HIPAA PRIVACY PRACTICES

As of April 14, 2003, the government mandated that healthcare providers provide a notice of privacy practice explaining how patients PROTECTIVE HEALTH INFORMATION (PHI) is kept private. It is the Health Insurance Portability and Accountability Act of 1996 (HIPAA). It is important that you read and understand how West Chester Cardiology, P.C. keeps your health information private. Please review this information carefully.

It is required for you to sign the attached statement indicating that the Notice of Privacy Practice policy has been made available to you.

UNDERSTANDING THE TYPE OF INFORMATION WE HAVE

We obtain health information from you and about you when we (our physicians and staff) provide care to you. This includes your name, date of birth, sex, demographic information and your health insurance information. You and other health care providers may provide us with health information such as your condition, diagnosis and treatment.

OUR PRIVACY COMMITMENT TO YOU

We care about your privacy. The information we collect about you is private. Only people who have both the need and the legal right may see your information. Unless you give us permission either in writing or verbally, we will only disclose your information for purposes of treatment, payment, and business operations when we are required by law to do so or for other reasons listed below:

• **Treatment:**

We may use or disclose medical information about you to provide and coordinate your health care. For example, we may notify your primary care physician about the care you receive from us.

• **Payment:**

We may use or disclose information so the care you receive can be properly billed. For example, we may send your health insurer a bill for your services that explains the treatment you received and why.

• **Business Operations:**

We may need to use and disclose information for your business operations. For example, we may give information to our billing company in order to collect from you or your health insurance company.

• **Appointment Reminders:**

We may contact you to give you appointment reminders or information about treatment changes, alternatives or other services that may be of interest to you.

• **As Required by Law and for Other Government Functions:**

We will release information when we are required by law or for other government functions. Examples of such releases would be for law enforcement of national security purposes, subpoenas or other court orders, communicable disease reporting, disaster relief, review of our activities by government agencies, to avert a serious threat to health or safety or in other kinds of emergencies.

• **Public Health and Safety:**

We may use or disclose information about you as necessary to prevent or reduce a serious threat to the health or safety of a person or the public. For example, we may disclose information about immunizations and certain diseases to public agencies.



• **For Research:**

Any patients involved in research studies will be required to sign a special consent form before being included.

• **Family and Friends:**

We may disclose your information to family members, friends, or others you identify to the extent it is relevant to their involvement with your care or payment for your care.

• **In the Event of Your Death:**

We may disclose your information to coroners, medical examiners and/or funeral homes.

• **With Your Permission:**

If you give us permission, we may use and disclose your PHI for purposes you list. You have the right to revoke consent for PHI disclosure.

• **Release Authorization:**

We will obtain written consent if we plan to use your protected health information for marketing.

Any disclosure the office makes that constitutes a sale of the protected information we will obtain written consent.

• **Fundraising:**

We will notify you if and when we institute fundraising communications with an option to opt out of receiving such communications.

• **Restricted information releases:**

If you pay for a service in full and out of your own pocket you can request that the office not disclose the information about the service to an insurance company. This request must be in writing and must state the specific service(s) not to be disclosed and the insurance company.

• **Breach notification:**

Any loss or inappropriate disclosure of protected information that is considered to be more than minimal probability that the data was used improperly will be reported to you.

YOUR PRIVACY RIGHTS

You have the following rights regarding your PHI:

• **Your Right to Inspect and Copy:**

In most cases, you have the right to look at or request copies of your medical records. You may be charged a fee for the cost of copying your records. (You may need to make an appointment to look at your records to assure that we will have it available to you).

• **Your Right to Amend:**

You may ask us to change your records if you believe there is a mistake. We can deny your request for certain reasons, but we must give you a written reason for our denial.



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• **Your Right to a List of Disclosures:**

You have the right to ask for a list of certain disclosures made after April 14, 2003. This list will not include information disclosed for treatment, payment, or health care operations. This list will not include information provided directly to you or your family, or information that was sent with your permission. It will not include information released without your name or other data that would identify you.

• **Your Right to Request Restrictions on Our Use or Disclosure Information:**

You can ask for limits on how your information is used or disclosed. We are not required to agree to such requests.

• **Your Right to Request Confidential Communications:**

You have the right to ask that we share information with you in a certain way or in a certain place. For example, you may ask us to send information to your work address instead of your home address. We will do our best to accommodate such a request.

CHANGES TO THIS NOTICE

We reserve the right to revise this notice. A revised notice will be effective for medical information we already have about you as well as any information we may receive in the future. We are required by law to comply with whatever notice is currently in effect.

HOW TO USE YOUR RIGHTS UNDER THIS NOTICE

If you want to use your rights under this notice, you may contact our office:

West Chester Cardiology, P.C.
531 Maple Avenue
West Chester, PA 19380
Phone: (610) 692-4382

You have the right to request alternative channels of communication.

COMPLAINTS TO THE FEDERAL GOVERNMENT

If you believe that your privacy rights have been violated, you have the right to file a complaint with the federal government. You may write to:

Office for Civil Rights, U.S. Department of Health and Human Services,
150 S. Independence Mall West, Suite 372
Public Ledger Building
Philadelphia, PA 19106-9111
Main Line (215) 861-4441. Hotline (800) 368-1019. FAX (215) 861-4431. TDD (215) 861-4440
E-Mail OCRComplaint@hhs.gov

You will not be penalized for filing a complaint with the federal government.



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CONFIRMATION OF RECEIPT

HIPAA Notice of Privacy rights from West Chester Cardiology, P.C. have been made available to me.

NAME: (Please print) _____

SIGNATURE: _____ DATE: ____ / ____ / ____