



# Heart and Vascular Institute of Wisconsin™

## Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information, used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you the patient significant new rights to understand and control how your health information is used. HIPAA provides penalties for entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes:

- *Treatment*- providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would be physical examination.
- *Payment*- activities such as obtaining, reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- *Health care operations*- include the business aspects of running our practice such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information which you can exercise by presenting a written request to Larry Sobal (Heart and Vascular Institute of WI CEO):

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction if we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

At times we need to take photographs. These are used for purposes of documentation in the Medical Record as an adjunct to clinical care. Your signature below provides your consent.

At times we have students or other health professionals shadowing our physicians and staff for learning, training and/or research purposes. Heart and Vascular Institute of Wisconsin has agreed to permit such individuals to observe and participate in patient care activities. Your signature below provides your consent to permit such individuals to observe and participate in your medical care during your appointment. You have the ability to withdraw your consent at any time during your appointment.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, retaliate against you for filing a complaint.

Please contact for more information or to file a complaint:

The US Department of Health & Human Services Office of Civil Rights  
200 Independent Ave, S.W.  
Washington, D.C. 20201  
(202) 619-0257  
Toll Free: 1-877-696-6775

**Patient name (printed):** \_\_\_\_\_

**Patient signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_