# Arizona Reproductive Medicine Specialists

## 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 confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered 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, payment and health care operations.

♦ **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
♦ **Payment** means such activities 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.

Our practice may disclose your health information without your authorization when permitted or required by law, including:

- ♦ For public health actions including reporting of certain communicable diseases
- ♦ To authorities when we suspect abuse, neglect, or domestic violence
- ♦ To avert a serious threat to your health & safety or that of others
- ♦ For judicial and administrative proceedings pursuant to an administrative order
- ♦ For governmental purposes such as military service or for national security
- ♦ For workers' compensation or similar programs as required by law
- ♦ To health oversight agencies
- ♦ For law enforcement purposes
- ♦ In the event of an emergency or for disaster relief
- ♦ In any other instance required by law

Practice may also disclose your information to family members, such as your spouse, and/or other persons involved in your care or payment for your care. Practice may leave messages for you at home or work about your visits or test results. If you do not want us to do so, please inform our Privacy officer in writing

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the privacy officer:

♦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 receive a list of disclosures of protected health information ♦The right to amend protected health information
♦The right to obtain a paper copy of this notice from us upon request ♦The right to inspect & copy your protected health information

We're 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.

The notice is effective as of March 1, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notices of Privacy practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office. You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint, please contact us:

**Arizona Reproductive Medicine Specialists**
1701 East Thomas Road | Building 1, Suite 101 | Phoenix, AZ 85016
Phone: 602.343.2767 | Fax: 602.343.2766

# NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Arizona Reproductive Medicine Specialists
1701 East Thomas Road | Building 1, Suite 101 | Phoenix, AZ 85016
Phone: 602.343.2767 | Fax: 602.343.2766

I understand that, under Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- ♦Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- ♦Obtain payment from third-party payers.
- ♦Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Signature _____

Date _____

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OFFICE USE ONLY

I ATTEMPTED TO OBTAIN THE PATIENT'S SIGNATURE IN ACKNOWLEDGEMENT ON THIS NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT BUT WAS UNABLE TO DO SO AS DOCUMENTED BELOW:

| Date: | Initials: | Reason: |
|---|---|---|
| | | |

**Arizona Reproductive Medicine Specialists**

Restriction / Confidential Communications Request

Patient Name: _____

Date of Birth: _____ Phone: _____

I authorize the release of my medical information from Arizona Reproductive Medicine Specialists to the following individuals:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I want the following type of information restricted:

_____
_____
_____

Please be advised that our office is not required to abide by the restrictions, but if we agree to do so, we must follow them.

Any information that will be used for treatment, payment, or healthcare operations will not be restricted. Please see notice of privacy practices for descriptions of the above statement.

Print Name: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

**ARIZONA REPRODUCTIVE MEDICINE SPECIALISTS**
**1701 E. Thomas Road, Building 1, Suite 101,Phoenix, Arizona 85016**
**Phone: 602-343-2767 Fax: 602.343.2766**
**www.arizonafertility.com**

Patient – Healthcare Provider Electronic Communication Agreement

Patient Name: _____ DOB: _____

Electronic communication, including but not limited to emails, internet based video conferencing through such applications as Skype, and FaceTime through iPhones and iPads, for example (hereinafter "Electronic Communications") provide an opportunity to communicate with your Healthcare Provider (hereinafter "ARMS") relative to issues that are **non-emergent, non-urgent or non-critical.** Electronic Communications are not a replacement for the interpersonal contact that is the very basis of the doctor-patient relationship.

The following is intended to assist you with your determination of whether you wish to supplement your healthcare experience by electronically communicating with members of the healthcare team Arizona Reproductive Medicine Specialists (ARMS).

**General Considerations**

- ARMS will treat Electronic Communication with the same degree of privacy and confidentially as written medical records. ARMS has taken reasonable step with internal information technology systems to protect the security and privacy of your personal identifying and health information in accordance with the security guidelines required by the Health Information Protection and Accountability Act of 1992 as amended (HIPAA).
- Standard email services, including, but not limited to AOL, OptOnline, Hotmail, and Gmail, are not secure. This means that the email messages are not encrypted and can be intercepted and read by unauthorized individuals.
- Electronic communication via internet based video conference providers, including, but not limited to Skype, claim to have safeguards, in place to protect your personal information from unauthorized disclosure. However, there is the possibility that viruses, Trojans or other malicious software may obtain you private information on your computer system and release and/or use your information without your knowledge. There may be other risks associated with internet communication with are unknown at this time.
- Transmitting email that contains protected health information through an email system that is not encrypted do not meet and electronic communication via internet based video conference providers may not meet the security guidelines as required by the HIPAA.

I have read and understood the above description of the risks and responsibilities associated with Electronic Communications with ARMS. I acknowledge that commonly used Electronic Communications are not secure and fall outside of the security requirements set forth by HIPPA.

I understand that I can withdraw this consent authorizing ARMS to communicate with me via Electronic Communications at any time by written notification to ARMS

I release and hold harmless ARMS, its physicians and their staff, employees, affiliates, agents, officers, directors and shareholders from any and all expenses, claims, actions, liabilities, attorney fees, damages, losses, of any kind, that I may have resulting from Electronic Communications between ARMS and me based on this authorization given to the ARMS to communicated with me via Electronic Communications. This release includes Arizona Reproductive Medicine Specialists' management services company and its offices, director, employees, representatives and agents.

Having been informed of the risks associated with Electronic Communications, I still desire to communicate with ARMS via electronic communications. In consideration for any desire to use Electronic Communications as an adjunct to in person office visits with ARMS, I do hereby authorize ARMS to engage in Electronic Communications with me.

Authorized Email Address: _____ Date _____

Authorized Email Address: _____ Date _____

Patient Signature _____ Patient Name _____
Partner Signature _____ Partner Name _____