THOMAS W. ELA, M.D., INC.
DIPLOMATE AMERICAN BOARD OF NEUROLOGY
CERTIFIED IN THE SUBSPECIALTY OF CLINICAL NEUROPHYSIOLOGY
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PERIPHERAL NERVE DISORDERS ADULT NEUROLOGY NEURODIAGNOSTIC TESTING

NOTICE OF PRIVACY PRACTICES

TO OUR PATIENTS: This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Uses and Disclosures of Protected Health Information (PHI): This practice is permitted to make disclosures of your PHI for the purpose of treatment, payment and health care operations. Examples include, but are not limited to, the following:

- We may consult with other health care providers regarding your treatment (prescriptions labwork, x-rays, etc).
- We may disclose PHI so we may bill your insurance and collect payment for you.
- We may use PHI to identify you for information about treatment or education.

Other uses and Disclosures of PHI Without Authorization: This practice is permitted or required by the HIPAA Privacy rule to use or disclose PHI without your written authorization as may be required by law or for the public-good. The uses and disclosures not otherwise described in this notice will only be made with your written authorization. Examples include but are not limited to, the following:

- We may report to the Department of Health, PHI that may place you or the public at risk, such as your ability to safely operate a motor vehicle.
- As authorized by Workers' Compensation laws, we may report to your carrier/employer, information related to workplace injuries or illnesses.
- In response to a court or administrative order, we may provide your PHI to the requesting party.

Your Individual Rights:

- ***Restriction Request:*** You have the right to request restrictions on the use and disclosure of PHI for treatment, payment or health care operations or that only certain individuals be involved in your care. Although the practice is not required to agree to such restrictions, we will accommodate reasonable requests, except when otherwise required by law.

- ξ ***Alternative Communication:*** You have a right to request alternate means of communication. You may request that we contact you at a certain location or in a particular manner. We will accommodate reasonable requests.
- ξ ***Inspect and Copy:*** You have a right to inspect and obtain a copy of your PHI and billing records. You must submit your request in writing to this practice's Privacy Official.
- ξ ***Amendment:*** You have a right to request an amendment to your PHI if you believe it is incorrect or incomplete. You must make your request in writing and submit it to the Privacy Official. You must provide us with a reason that supports your request for amendment.
- ξ ***Accounting:*** You have a right to receive an accounting of all disclosures of your PHI.
- ξ ***Paper copy:*** You have a right to obtain a paper copy of this notice at any time.
- ξ ***Complaints:*** You have a right to file a complaint if you believe your privacy rights have been violated. This must be filed in writing with the Privacy Officer. You will not be intimidated, threatened, coerced or discriminated against for filing a complaint.
- ξ ***Privacy Officer:*** Any employee or physician of this practice can provide you the name of the Privacy Officer, who can be reached at the address and telephone number on this document.
- ξ ***Effective Date:*** This notice takes effect upon acknowledgment by you..

The Medical Practice's Duties:

- ξ ***Legal Duties:*** This medical practice is required by law to maintain the privacy of your PHI and is required to abide by the terms of the "Notice of Privacy Practices".
- ξ ***Revisions:*** Revisions of amendments to this notice will be provided upon request and posted in the Reception Room.
- ξ ***Training:*** It is the responsibility of the practice to train it's employees on current regulations. If they are unable to assist you, they will refer you to the Privacy Officer.

Right to Revoke This Authorization: You may revoke this authorization at any time, except to the extent we have taken previous action based on the authorization.

I hereby acknowledge that I have been presented this "Notice of Privacy Practices".

Date: _____ Patient: _____

Signature: _____

For more information about HIPAA or to file a complaint:

the U.S.