

## **Notice of Privacy Practices** ***We Care About Your Privacy***

### **Our Policy Regarding Health Information**

The privacy of your health information is important to us. We understand that your health information is personal and we are committed to protecting it. We will keep a record of the care and services you receive at our office. We need these records to provide you with quality healthcare. This notice tells you the ways we may use and share health information about you. It also describes your rights and certain duties we have regarding your health information. Please review it carefully.

### **Our Legal Duty**

#### **Law requires us to:**

- 1.) Keep your health information private.
- 2.) Give you this notice describing our duties, privacy practices, and your rights regarding your health information.
- 3.) Follow the terms of the current notice.

#### **We have the right to:**

- 1.) Change our privacy practices and the terms of this notice at any time, provided the changes are permitted by law.
- 2.) Make the changes of our privacy practices and the new terms of this notice effective for all health information we keep, including information created or received prior to the changes.

#### **Notice of change to privacy practices:**

- 1.) Before we make an important change in our privacy practices, we will change this notice and make the new notice available on request.

### **Use and Disclosure of Your Information**

The following section describes the different ways we may use and disclose health information. We will not use or disclose your information for any reason not listed below, without your specific written authorization. Any authorization you give may be revoked at any time by writing to us.

#### **For Treatment:**

We may use and disclose your information about you to provide you with treatment or services under the scope of our practice. We may disclose health information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share health information about you with other healthcare providers to assist them in taking care of you.

#### **For Payment:**

We may use and disclose your information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your health information.

**For Healthcare Operations:**

We may use and disclose your information for our healthcare operations. This might include measuring and improving quality, evaluating the performance of employees, and getting the accreditation, certificates, licenses, and credentials we need to serve you.

**Additional Uses and Disclosures:**

In addition we may also use your health information for the following purposes.

*Notification:*

We may use and disclose your information to notify or help notify: a family member or another person who may be responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share. In the case of an emergency, and/or you are not able to give or refuse permission, we will only share the health information that is directly necessary for your healthcare, according to our professional judgment to make decisions in your best interest about allowing someone to pick up supplements, supplies, x-ray or other medical information for you.

*Workers Compensation:*

We may disclose health information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.

*Health Oversight Activities:*

We may use and disclose your information to an agency providing health oversight for oversight activities authorized by law: including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

*Appointment Reminders:*

We may call you prior to your scheduled appointment to remind you of your appointment time. If you are not available, we will leave a reminder message on your answering machine/voice mail or with the person answering the phone. NO PERSONAL HEALTH INFORMATION WILL BE DISCLOSED, other than the date and time of your appointment along with a request to call our office if you need to cancel or reschedule, during this message.

*Change of Ownership:*

In the event that Gajda Health Plus Network is sold or merged with another organization, your health information/record will become the property of the new owner.

**Your Health Information Rights**

- 1.) You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Gajda Health Plus Network is not required to agree to the restriction that you requested.
- 2.) You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

- 3.) You have the right to inspect and copy your health information.
- 4.) You have the right to request that Gajda Health Plus Network amend your protected health information. Please be advised, however, that Gajda Health Plus Network is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial and information about how you can disagree with the denial.
- 5.) You have the right to receive an accounting of disclosures of your protected health information created by Gajda Health Plus Network.
- 6.) You have the right to a paper copy of this Notice of Privacy Practices at any time upon request.

### **Complaints**

If you have any questions about this notice or complaints about how Gajda Health Plus Network has handled your health information, please ask the receptionist for more information on how to submit a formal complaint.

### **Your Signature**

I have read this notice and understand my rights contained in this notice. BY way of my signature, I provide Gajda Health Plus Network with my authorization and consent to use and disclose my protected health information for the purposes of treatment, payment, and healthcare operations as described in the privacy notice.

X \_\_\_\_\_

Please Sign and Date

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