



MILE HIGH Family MEDICINE
a higher standard of care for your family

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NOTICE OF PRIVACY PRACTICES

Effective December 1, 2006

This notice describes how your health information may be used and disclosed and how you can access this information.

Mile High Family Medicine is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing services to you. Such information may include documenting your symptoms, examination, test results, diagnoses, treatment, and applying for future care of treatment. It also includes billing documents for those services.

USES OF HEALTH CARE INFORMATION FOR TREATMENT PURPOSES EXAMPLES:

- A medical assistant performs vital signs and collects health information about you and records it in your health record.
- The physician or other designated health providers may determine they need to consult with another health care provider during the course of your treatment. Your health information may then be shared with the other provider to obtain his input.
- In the process of providing care, your health information will be discussed in our office in the following locations: reception desk, check-out desk, nurse's stations, exam rooms, laboratory, and conference room.

USES OF HEALTH CARE INFORMATION FOR PURPOSES OF PAYMENT EXAMPLE:

- Requests will be submitted for payment to your health insurance company. The health insurance company (or other business associate assisting in obtaining payment) requests information regarding medical care given. We will provide information to them about you and the care given.

USES OF HEALTH CARE INFORMATION FOR PURPOSES OF HEALTH CARE OPERATIONS EXAMPLES:

- In order to conduct business, we obtain services from our insurers or other business associates. These include, but are not limited to, protocol and clinical guidelines, credentialing services, quality improvement, outcome evaluation, medical review, legal services, quality assessment, and insurance. We will then share your health information with such insurers or other business associates as necessary to obtain these services.
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a request to our office. An accounting will not include uses and disclosures of information for treatment, payment, or operations; disclosures or uses made to you or made at your request; uses or disclosures made pursuant to an authorization signed by you; uses or disclosures to notify family or others responsible for your care of your location, condition or your death.

- Revoke authorizations that you made previously to use or disclose information by delivering a written revocation to our office, except to the extent information or action has already been taken.

OUR RESPONSIBILITIES

The office is required to:

- Maintain privacy of your health information as required by law;
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and,
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy.

YOUR HEALTH INFORMATION RIGHTS

The health and billing records we maintain are the physical property of the office. The information in it, however, belongs to you. You have a right to:

- Request to see and receive a copy of your health and billing information by submitting a written request to our office. We are permitted by HIPAA law to charge a fee for processing your request;
- Obtain a paper copy of the current Notice of Privacy Practices for Protected Health Information (“Notice”) by making a request at our office;
- Request restriction on certain uses and disclosures of your health information by delivering the request to our office - we are not required to grant the request, but we will comply with any request granted;
- Appeal a denial of access to your protected health information, except in certain circumstances;
- Request the transfer of copies of your health information to another practice;
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a request to our office. We may deny your request if you ask us to amend information that:
 - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
 - Is not a part of the health information kept by or for the office;
 - Is not part of the information that you would be permitted to inspect and copy; or
 - Is accurate and complete.

If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be maintained with your records.

If you would like to exercise any of the rights as they have been stated, please contact the office manager and/or the privacy officer, in person or in writing, during regular business hours. They will inform you of the steps needed to be taken to exercise your rights.

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE
OF PRIVACY PRACTICES**

I, (patient name) _____,
DOB: _____ have received a copy of this office's
Notice of Privacy Practices.

Please Print Name of Patient (or Parent/Guardian/Guarantor if under 17)

Signature of Patient (or Parent/Guardian/Guarantor if under 17)

Date

- I authorize the following individuals to receive information
regarding my medical information. (Please list below)

- Please check if you authorize our office to leave detailed messages on
your answering machine and/or voicemail.

- I refuse to sign this document (*please print name on line below for documentation*)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but
acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify)