

NOTICE OF PRIVACY PRACTICES – SHORT FORM

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

EFFECTIVE DATE OF THIS NOTICE: 4-15-03

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN ACCESS YOUR INDIVIDUAL IDENTIFIABLE HEALTH INFORMATION

PLEASE REVIEW THIS NOTICE CAREFULLY

Our practice is committed to educating our patients about health care issues that affect them. As a result, we are providing you with general information about the Privacy Rule, a federal regulation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) along with a brief overview of our Notice of Privacy. Our Practice is compliant with these rules.

What is HIPAA and how does the privacy rule affect you?

When HIPAA was passed in August 1996, this gave the Federal Government the ability to mandate how health care plans, providers and clearinghouses store and send a patient's personal information as it relates to health care. The privacy rule was created to protect your rights as a patient. We are required by Law to be in compliance with this regulation. Under the Privacy Rule, you are guaranteed access to your medical records, allowed control over how your protected information (PHI) is used and disclosed and you are allowed to take action if the Practice's policy compromises your health information.

What is Individuality Identifiable Health Information (IIHI)?

Any health information you provide our practice including but not limited to you mailing address and information that is created and retained by our practice or received by another health care provider that relates to treatment and/or identifies you as an individual.

What is the Notice of Privacy Practice?

Our practice has an official Notice of Privacy Practice posted in our office informing Patients about their rights surrounding protection of IIHI. This Notice applies to all records created and/or retained in our office. We can update this Notice at any time. It will be posted or you can ask for a copy at any time.

The following categories describe the different ways in which we may use and disclose your IIHI:-

Treatment
Payment
Health Care Operations

Appointment Reminders
Treatment Options

Release of information to Family/Friends
Disclosure Required by Law
Health – Related Benefits and Services

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for The Oasis Institute (known as Oasis Institute) to use and disclose protected Health Information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO).

I have the right to review the Notice of Privacy Practices prior to signing this consent Oasis Institute reserves the right to revise this Notice at any time. A copy of this revision can be obtained at any time by forwarding a written request to this office Attention: Privacy Officer.

With this consent Oasis Institute may email to my home or alternative locations any items that may assist the practice in carrying out TPO, such as appointment reminders and statements as long as they are marked Personal and Confidential.

With this consent Oasis Institute may call my home or alternative locations and leave messages on voicemail or in person in reference to any items that may assist the practice in carrying out TPO, such as appointment reminders and statements as long as the message is stated who it is for.

With this consent Oasis Institute may call or email my home or alternative locations with any items that may assist the practice in carrying out TPO, such as appointment reminders and statements. I have the right to request that Oasis Institute restrict how they use or disclose my PHI to carry out TPO. However, the practice is not required to agree to my restrictions but if it does, it is bound by this agreement. By signing this form I am consenting to Oasis Institute use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing at any time except to the extent that the practice had already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Oasis Institute can and may decline to provide me treatment.

Signature of Patient or Legal Guardian

Date

Print Patient's Name

Print Name of Legal Guardian

THE OASIS INSTITUTE
20880 West Dixie Highway, Suite 101
Aventura, FL 33180
305-682-8471 Fax: 305-682-1855

The following categories describe unique situations in which we may use or disclose your identifiable health information:-

Public Health Risks	Health Oversight Activities	Lawsuits and Similar Cases	Law Enforcement
Deceased Patients	Organ & Tissue Donation	Serious Threat to Health or Safety	Research
Military	National Security	Worker's Compensation	

What are your rights concerning your Individual Identifiable Health Information (IIHI)?

You have the right regarding the IIHI that we maintain about you. In our Notice of Privacy you can view the policies and procedures you will need to follow from areas listed below:-

1. Confidential communications
2. Requesting Restrictions
3. Inspection and Copies
4. Amendment
5. Accounting of Disclosures
6. Rights to a paper copy of this notice
7. Rights to file a complaint
8. Right to provide an authorization for other uses and disclosures

If you have any questions regarding this notice or our Health Information Privacy Policies, please contact in writing:-

The Oasis Institute
20880 West Dixie Highway
Suite 101
Miami, Fl. 33180
Attention: Privacy Officer

I have read the short notice provided by Oasis Institute and have been informed of how to obtain more information regarding the Notice of Privacy.

Signature of Patient or Legal Guardian

Date

Print Patient's Name

Print Name of Legal Guardian