IMMEDIATE CARE, PA
DR. SHARAB MOHAMED
3345 JOG ROAD
GREENACRES, FL. 33467
(561) 965-4855

YOUR RIGHTS

FOLLOWING IS A STATEMENT OF YOUR RIGHTS WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION.

YOU HAVE THE RIGHT TO INSPECT AND COPY YOUR PROTECTED HEALTH INFORMATION. UNDER FEDERAL LAW, HOWEVER, YOU MAY NOT INSPECT OF COPY THE FOLLOWING RECORDS; PSYCHOTHERAPY NOTES, INFORMATION COMPILED IN REASONABLE ANTICIPATION OF, OR USE IN, A CIVIL, CRIMINAL, OR ADMINISTRATIVE ACTION OR PROCEEDING, AND PROTECTED HEALTH INFORMATION THAT IS SUBJECT TO LAW THAT PROHIBITS ACCESS TO PROTECTED HEALTH INFORMATION.

YOU HAVE THE RIGHT TO REQUEST A RESTRICTION OF YOUR PROTECTED HEALTH INFORMATION. THIS MEANS YOU MAY ASK US NOT TO USE OR DISCLOSE ANY PART OF YOUR PROTECTED HEALTH INFORMATION FOR THE PRUPOSES OF TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS. YOU MAY ALSO REQUEST THAT ANY PART OF YOUR PROTECTED HEALTH INFORMATION NOT BE DISCLOSED TO FAMILY MEMBERS OR FRIENDS WHO MAY BE INVOLVED IN YOUR CARE OR FOR NOTIFICATION PURPOSE AS DESCRIBED IN THIS NOTICE OF PRIVACY PRACTICES. YOUR REQUEST MUST STATE THE SPECIFIC RESTRICTION REQUESTED AND WHOM YOU WANT THE RESTRICTION TO APPLY.

YOUR PHYSICIAN IS NOT REQUIRED TO AGREE TO A RESTRICTION THAT YOU MAY REQUEST IF PHYSICIAN BELIEVES IT IS IN YOUR BEST INTEREST TO PERMIT USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION, YOUR PROTECTED HEALTH INFORMATION WILL NOT BE RESTRICTED. YOU THEN HAVE THE RIGHT TO USE ANOTHER HEALTCARE PROFESSIONAL.

YOU HAVE THE RIGHT TO REQUEST TO RECEIVE CONFIDENTIAL COMMICATIONS FROM US BY ALTERNATIVE MEANS OR AT AN ALTERNATIVE LOCATION. YOU HAVE THE RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE FROM US. UPON REQUEST, EVEN IF YOU HAVE AGREED TO ACCEPT THIS NOTICE ALTERNATIVELY I.E. ELECTRONICALLY.

YOU HAVE THE RIGHT TO HAVE YOUR PHYSICIAN AMEND YOUR PROTECTED HEALTH INFORMATION. IF WE DENY YOUR REQUEST FOR AMENDMENT, YOU HAVE THE RIGHT TO FILE A STATEMENT OF DISAGREEMENT WITH US AND WE MAY PREPARE A REBUTTAL TO YOUR STATEMENT AND WILL PROVIDE YOU WITH A COPY OF ANY SUCH REBUTTAL..

YOU HAVE THE RIGHT TO RECEIVE AN ACCOUNTING OF CERTAIN DISCLOSURES WE HAVE MADE, IF ANY, OF YOUR PROTECTED HEALTH INFORMATION. WE RESERVE THE RIGHT TO CHANGE THE TERMS OF THIS NOTICE AND WILL INFORM YOU BY MAIL OF ANY CHANGES. YOU THEN HAVE THE RIGHT TO OBJECT OR WITHDRAW AS PROVIDED IN THIS NOTICE.

COMPLAINTS

YOU MAY COMPLAIN TO US OR TO THE SECRETARY OF HEALTH AND HUMAN SERVICES IF YOU BELIEVE YOUR PRIVACY RIGHTS HAVE BEEN VIOLATED BY US. YOU MAY FILE A COMPLAINT WITH US BY NOTIFYING OUR PRIVACY CONTACT OF YOUR COMPLAINT. WE WILL NOT RETALIATE AGAINST YOU FOR FILING A COMPLAINT.

THIS NOTICE WAS PUBLISHED AND BECOMES EFFECTIVE ON/OR BEFORE APRIL 14, 2003.

WE ARE REQUIRED BY LAW TO MAINTAIN THE PRIVACY OF, AND PROVIDE INDIVIDUALS WITH THIS NOTICE OF OUR LEGAL DUTIES AND PRIVACY PRACTICES WITH RESPECT TO PROTECTED HEALTH INFORMATION. IF YOU HAVE ANY OBJECTIONS TO THIS FORM, PLEASE ASK TO SPEAK WITH OUR HIPPA COMPLIANCE OFFICER IN PERSON OR BY PHONE AT OUR MAIN PHONE NUMER.

SIGNATURE BELOW IS ONLY ACKNOWLEGEMENT THAT YOU HAVE RECEIVED THIS NOTICE OF OUR PRIVACY PRACTICES.

PRINT NAME _____ *DATE* _____

SIGNATURE _____