Matthew Mardiney, MD
ADVANCED
ALLERGY & ASTHMA
CENTERS

NOTICE OF PRIVACY PRACTICES

PATIENT NAME: _____ DOB: _____

Scope of our Privacy Procedures

This notice describes the policy practices of all employees of Advanced Allergy & Asthma Centers. We pledge that all of your health information will remain confidential at all times. This notice will tell you about the ways we may use your health information. You are receiving this notice as required by law.

We may disclose your health information under the following circumstances:

For Treatment	We may use your health information in consulting with nurses, physicians and other providers.
For Payment	We may disclose your health information to your insurance company to secure reimbursement for services Rendered.
Appointment Reminders	We may disclose information about you when making or verifying your appointment, this may be on answering machine or in the form of an email or letter.
Business Associates	We may disclose your health information to outside business associates such as transcription services or collection agencies.
Individuals involved in Your care or payment of your care	We may disclose your health information to a family member or others who may be responsible for you or to pay for your care.
As required by law	We will disclose your health information as required by state or federal law.
Threats to public safety	We may disclose your health information if there is a serious threat to public safety.
Public Health Risks	We will disclose your health information to prevent or control disease, to report abuse, to report problems with medications, to notify patients of recalls or to notify a person who may have been exposed to disease or another serious medical condition.
Health Oversight	We may disclose your health information to health oversight agencies. Such activities may include audits, investigations and inspections.
Legal Issues	We may disclose your health information in response to a court order, subpoena, to locate a witness, a crime victim or any other suspected criminal conduct.

Your Rights Regarding Your Health Information

Authorization	Other than purposes listed above the only people to receive your health information are:

_____ _____

Print Person's Name and relation **Print Person's Name and relation**

Right to inspect records	You have the right to inspect any clinical or billing date we have about you. There may be a copy fee.
Right to amend records	You have the right to amend or change your records at any time with physician approval.
Right to restrict	You have the right to ask us to restrict use of your information, however, we are not required to agree.

We reserve the right to change this notice at any time

I understand that I have received a copy of the Notice of privacy practices for Advanced Allergy & Asthma Centers as required by HIPAA (Health Insurance Portability and Accountability Act). I understand that only one signature per lifetime is required for any services rendered at Advanced Allergy & Asthma Centers.

Signature: _____ Date: _____

Print Name: _____ Relation to Patient: _____

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443-987-6998

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Dedicated to excellence in both adult and pediatric allergy

American Board of Allergy and Immunology