BEVERLY FISCHER, MD
THE ADVANCED CENTER FOR PLASTIC SURGERY
(410) 308-4700

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) PRIVACY RULE

PURPOSE

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. We are required by the HIPAA privacy rule under federal and state law to protect the privacy of our patient medical information.

OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our practice. These records may be created in a physical form (i.e. paper), electronic form (i.e. computer, “cloud”) or other form. These records may include photos. These records may include video utilizing ipad medical record technology. Video technology helps in recording discussions between the doctor and patient. Video may also help record complex motion that photos cannot record, such as facial motion, eyelid motion or hand motion.

The medical record helps us provide you with quality care and assists us in complying with certain medical and legal requirements. The health and billing records we maintain are the physical property of the office of Advanced Center for Plastic Surgery and Dr. Beverly Fischer. However, you may inspect and obtain a copy for your information. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following section describes different ways that we use and disclose medical information. For each kind of use or disclosure, we will explain what we mean and give examples. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us. However, you may not revoke this authorization for any actions taken before receipt of my written notice to revoke this authorization.

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FOR TREATMENT

We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians or other people who are taking care of you.

FOR PAYMENT USING CREDIT CARDS, DEBIT CARDS, ELECTRONIC PAYMENTS, AND FINANCING

It may become necessary to release your information to financial parties, credit card entities, banks, and financing companies when requested to facilitate your payment. Services that are performed that are paid with a credit card, electronic payment, debit card or financing third parties are not eligible for payment challenges after services are provided. The patient irrevocably consents to allow our practice to use and disclose protected health information to a credit card entity, bank or financing company when they request such information to process an account and assist with payment.

Patient Name (Printed): ______________________________

Patient Signature: ______________________________

Date:___________________________________