



Patient Rights

UNDER THE NEW HIPAA GUIDELINES, YOU HAVE SPECIFIC RIGHTS CONCERNING THE USE OF AND DISCLOSURE OF YOUR PROTECTED MEDICAL INFORMATION. PLEASE READ THE FOLLOWING CAREFULLY SO THAT YOU UNDERSTAND THOSE RIGHTS.

Right to Request Restrictions: You have the right to request restrictions and limitations on how your Protected Medical Information is used or disclosed. This is done through a written request specifying the limitations that you wish to have placed. We will make every effort to agree to reasonable requests that do not complicate or compromise your care. If we agree to your requested restrictions, we will abide by them until such time as the patient removes them in writing. New Cedar Lake Surgery Center may not be able to safely or thoroughly conduct your care with these restrictions, and is not required to agree to them.

Right for Consent: It is your right that your written consent is required prior to the use or disclosure of your psychotherapy notes or the use of your Protected Health Information for marketing purposes.

Right to Inspect and Copy Your Information: You have the right to inspect and obtain a copy of Protected Medical Information that may be used to make treatment decisions in your care. Simply make the request in writing to our office for a copy of your information. A small fee may be charged for copies to defray the additional office expense.

Right to Amend: You have the right to make a written request to amend medical information that you believe is inaccurate or incomplete. We have every interest in maintaining highly accurate records about you and welcome the chance to further improve them. Please submit any changes to us in writing. However, New Cedar Lake Surgery Center may deny the request if we feel that the original information is accurate or complete.

Right to Request Confidential Communications: You have the right to request that our practice, or its physicians, communicate with you in a certain manner (for example: e-mail, mail, cell phone, etc.). This is to assure that you are able to select the method that most protects your privacy. Your request will need to be submitted in writing.

Right to an Accounting of Disclosures: You have the right to request an accounting of all disclosures our practice has made of your Protected Health Information over a reasonable period of time. You may be charged an administrative fee for each list requested.

Right to be notified of Breach: You have the right to be notified in the event of a breach of your Protected Health Information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

Right to request restriction of Protected Health Information: If you pay in full out of pocket for your treatment, you can instruct us not to share information about your treatment with your health plan; if the request is not required by law.

Right to a copy of the Privacy Statement and Statement of Patient Rights: You will be furnished with a copy of this document when you first register with our practice. Additional copies will be provided on request. New Cedar Lake Surgery Center has a website at www.cedarlk.com where the document may be downloaded.

The Practice's Responsibilities

New Cedar Lake Surgery Center and its Physicians are required by law to maintain the Patient Privacy Notice and abide by its terms from its effective date. If our privacy practices are modified in the future, and these modifications affect use and disclosure of previously obtained Protected Health Information, the modified policy can be obtained from our practice on demand. In the event that we change our policy, or if a change in the law affects the patient's rights or our responsibility, we will promptly amend our privacy policy and advise our patients of the change.

Point of Contact: If you have concerns about your Protected Medical Information, or need additional help in understanding how and under what circumstances it is used, please contact Human Resources.

Effective Date of this Privacy Policy: October 10, 2013

I have reviewed the Patient Privacy Notice and have received a copy.

Patient Signature: _____

Date: _____

Printed Name: _____

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