Mississippi Ear, Nose & Throat SURGICAL ASSOCIATES

HIPPA PRIVACY NOTICE

YOU HAVE THE FOLLOWING RIGHTS REGARDING YOUR MEDICAL INFORMATION

- The right to requests restrictions on certain uses and disclosures of your Protected Health Information (PHI). We are not required to agree to your requested restriction, but if we do, we will honor it.
- The right to receive communications from us in a confidential manner.
- The right to inspect and copy your medical information. This right is subject to certain specific exceptions and you may be charged a reasonable fee for any copies of your records.
- The right to request an amendment of your medical information. We may deny your request for certain specific reasons, and, if denied, we will provide you with written explanation for the denial and information regarding further rights you would have at that point.
- Th right to receive an accounting of the disclosures of your medical information in the six years prior to your request (following April 14, 2003), except for disclosures for treatment, payment, or practice operational purposes, disclosure pursuant to an authorization and certain other specific disclosure types.
- The right to request a paper copy of this Notice of Privacy Practices or Protected Health Information.
- The right to complain to the Practice and/or to the U/S/ Department of Health and human Services, if you believe that the Practice has violated your privacy rights. To complain to the Practice, please call:

Melissa Smith, Compliance Officer at (601)709-7700

If you choose to file a complaint, you will not be retaliated against in any way.

THIS NOTICE IS EFFECTIVE AS OF OCTOBER 1, 2012

I acknowledge that I have received and had an opportunity to ask questions concerning the Practice's Notice of Privacy Practices for Protected Health Information.

Further, by signing below I provide my permission for this facility to use and disclose my medical information for the permitted purposes of treatment, payment and healthcare options as discussed in the Notice of Privacy Practice.

_____ _____

Patient Signature Date

AUTHORIZATION TO RELEASE INFORMATION

Please list name(s) of the Personal Representative(s) of the patient below. List anyone you wish to have access to any of your personal health information, billing information or any aspects of your medical care. If a person(s) name is not listed below, we will not be able to discuss and/or release any of your information with them.

Name :_____ Relationship:_____Date:_____

Name :_____ Relationship:_____Date:_____