Orthopaedic Associates of Osceola
604 Oak Commons Blvd., Kissimmee, FL 34741
Phone: 407-846-6004 Fax: 407-846-1330

NOTICE OF PRIVACY PRACTICES

This notice describes how your health information may be used and disclosed and how you can access this information. Please review carefully.

At Orthopaedic Associates of Osceola, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice. The law permits us to use or disclose health information to those involved in your treatment. For example, a review of your file by a specialist or referring doctor whom we may involve in your care. We may use or disclose health information for payment of your services. For example, we may send a report of your progress to your insurance company. We may use or disclose health information as part of our normal healthcare operations. For example, one of our staff will enter your information into our computer.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy. We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answer machine or with the person who answers the phone.
In an emergency, we may disclose health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law.
If this practice is sold, your information will become the property of the new owner. Except as described above, this practice we'll not use or disclose your health information without your prior written authorization.

You may request in writing that we do not use or disclosure your health information as described above. We will let you know if we can fulfill your request. You have the right to know of any uses or disclosures we make with your health information beyond the normal above uses. As we will need to contact you from time to time, we will use whatever address or telephone number you prefer. You have the right to transfer copies of your health information to another practice. We will mail your files for you. You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but we'll be happy to include your statements in your file. If we agree to an amendment or change, we will not remove or alter earlier documents, but will add new information.

You have the right to receive a copy of this notice. If we change any of the details of this notice, we will notify you of the changes in writing. You may file a complaint with the Department of Health and Human Services, 200 Independence Ave., S.W., Room 509F,Washington,DC 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our privacy officer, Stacey Crawley at 321-402-5043. This notice goes into effect as of April 14, 2003.

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Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have read and had the opportunity to ask questions concerning the above named practice's Notice of Privacy Practices.

This is to acknowledge that you have authorized us to:

Leave a detailed message, which may include test results, diagnosis or billing information on voicemail or answering machine _____ yes _____ no

If not at home, leave a detailed message with the individual answering the phone, to include the same above information _____ yes _____ no

Please name the individuals that you hereby authorize on your behalf to speak with this office regarding all aspects of your medical chart, i.e., health conditions, medications, results and financial information.

NAME: _____ Relationship: _____

NAME: _____ Relationship: _____

NAME: _____ Relationship: _____

_____ _____
Patient or Patient Representative Signature Date

_____
Print Patient's legal name

_____
if signed by representative, print name of representative