MID-COUNTY
DERMATOLOGY

Notice of Privacy Practices
3009 N. Ballas Road, Building B, Suite 208
St. Louis, MO 63131
314-994-0200

**This Notice of Privacy Practices outlines how your personal medical information may be used and disclosed and you can access this information.

If you have any questions about this notice, please contact our office at 573-803-3331.

OUR OBLIGATIONS:
-Maintain the privacy of protected health information
-Give you this notice of our legal duties and privacy practices regarding personal health information

The following describes the ways we may use and disclose health information that identifies you ("Protected Health Information" or "PHI"). Except for the purposes described below, we will use and disclose Protected Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

We may use and disclose PHI **for your treatment** and to provide you with treatment-related health care services. For example, we may disclose PHI to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

We may use and disclose PHI so that we or others **may bill and receive payment** from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

We may use and disclose PHI **for health care operations purposes**. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

We may use and disclose PHI **to contact you to remind you that you have an appointment with us**. We also may use and disclose PHI to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

We may use and disclose PHI to you via email or text message. If you initiate an email to us, you agree we may communicate to you via email, including communications disclosing your Health Information. You acknowledge that such email is plain-text and not encrypted or secure. You acknowledge we may communicate to you via text message if you have provided us with your mobile number and that such text messages are not encrypted or secure.

To respond to a comment or question from you in a public or online forum. If you initiate a comment or question to us in a public forum, such as an event or seminar, or an online forum including social media websites, online review websites, blogs or other internet forums, you agree we may use and disclose your PHI in responding to your questions or comments.

When appropriate, we **may share PHI with a person who is involved in your medical care (if you have designated so)** or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

We will disclose PHI **when required to do so by international, federal, state or local law.**

ACKNOWLEDGEMENT OF RECEIPT
By signing this form, you acknowledge receipt of and agree to the Notice of Privacy Practices of Alliance Health. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information.

I acknowledge receipt of and agree to the Notice of Privacy Practices of Alliance Health.

Print Name: _____ Date: _____
(patient/parent/conservator/guardian)

Signature: _____ Date: _____
(patient/parent/conservator/guardian)

I give permission to discuss my medical care and/or financial obligations with:

Name _____ Relationship _____ Phone Number _____