TEXAS LUNG CENTER, P. A.

REVISION TO PRIVACY NOTICE

(Revised: August 28, 2014)

In compliance with the state regulations for the Omnibus Health Insurance Portability and Accountability Act (HIPAA)

This notice is to inform Texas Lung Center, P. A. patients of their rights and Texas Lung Center, P. A.'s responsibility to keep their health information private.

Additional Patient Information that Requires Authorization:

(New notice) The release of Psychotherapy Notes – (Kept separate from original patient chart).

(New notice) Information for Fundraising Purposes (Patient may opt-out).

(New notice) A patient who pays for a service in full and out-of-pocket can request that the office not disclose any information about that service to an insurance company.

The request has to be in writing and has to identify what information is restricted and what the insurance company is not to receive it. (This applies to **all** payers)

I am aware that if there is any breach in my protected health information Texas Lung Center, P. A. will notify me in writing.

_____

(Print Patient Name)

_____ _____

(Patient Signature) (Date)

To file a complaint, you may either call or send a written letter. Texas Lung Center, P. A. will not retaliate against any individual who files a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

In addition, if you have any questions about this Notice, please contact Texas Lung Center, P.A.'s HIPAA Officer at the address or phone listed below.

Texas Lung Center, P. A.
3600 Gaston Ave., Suite 806
Dallas, TX 75246
(214) 824-8521

VII. ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS

By signing below, you acknowledge that you have received this *Notice of Privacy Practices* prior to any service being provided to you by Texas Lung Center, P. A., and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure of my information (specify as applicable):

_____
_____
_____
_____
_____

Patient Name: _____ DOB: _____
(Please Print)

SIGNATURES:

Patient/Legal Guardian: _____ Date: _____

If Legal Guardian, relationship to Patient: _____

Witness (optional): _____ Date: _____