DFW Allergist

Dr. Zachary W. Marshall, M.D.
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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this document carefully.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, written, or spoken, are kept properly confidential. This Act gives you, the patient, significant rights to understand and control how your health information is used. When you receive treatment from our clinic, we receive, create and maintain information about you for health care operations, treatment, and payment for services. We will not use or disclose your information without your written authorization (permission) except as described in this notice.

How We May Use and Disclose Your Health Information

We may use and disclose your health information without your authorization for treatment, payment, and health care operation purposes. (*Treatment* means providing, coordinating, or managing health care and related services by health providers. *Payment* means activities such as obtaining reimbursement, confirming coverage, billing or collection, and utilization review. *Health care operations* means the business aspects of practice such as quality assessment and quality review.) Examples of appropriate health information use include but are not limited to:

- Using or sharing your health information with other health care providers involved in your treatment or with a pharmacy that is filling your prescription.
- Using or sharing your health information with your health plan to obtain payment for services or using your health information to determine your eligibility for government benefits in a health plan.
- Using or sharing your health information to run our business, to evaluate provider performance, to educate health professionals, or for general administrative activities as legally allowed.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may share your health information with our business associates who need the information to perform services on our behalf and agree to protect the privacy and security of your health information.

We may use or share your health information without your authorization as authorized by law for our patient directory, to family or friends involved in your care if you authorize this, or to a disaster relief agency for purposes of notifying your family or friends of your location and status in an emergency situation. We may use and disclose your health information without your authorization to contact you for activities permitted by law and agency policy, for example: providing appointment information, describing or recommending treatment alternatives, and providing information about health-related benefits and services. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may also use and disclose your health information without your authorization for the following purposes: for public health activities such as reporting diseases, injuries, births or deaths to a public health authority authorized to receive this information, or to report medication issues or medical device issues to the FDA; to comply with workers compensation laws and similar programs; to alert appropriate authorities in situations required or permitted by local, state, or federal law; for incidental disclosures such as when information is overheard in a waiting room despite reasonable steps to keep information confidential; and as otherwise required or permitted by local, state, or federal law.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

Your Privacy Rights

Your health record is the property of Dr. Zachary W. Marshall, MD. You can exercise your rights with respect to your protected health information by presenting a written request to Zachary W. Marshall, MD. You have the following rights with respect to your protected health information; you may:

- Inspect and copy your health information, including lab reports, upon written request and subject to some exceptions. We may charge you a reasonable, cost-based fee for providing records as permitted by law.
- Receive confidential communications of your health information, such as requesting that we contact you at a certain address or phone number. You may be required to make the request in writing with a statement or explanation for the request.
- Request amendment of your health information in our records. All requests to amend health information must be made in writing and include a reason for the request.
- Request an accounting (a list) of certain disclosures of your health information that we make without your authorization. You have the right to receive one accounting free of charge in any twelve-month period.
- Request that we restrict how we use and disclose your health information for treatment, payment, and health care operations, or to your family and friends. We are not required to agree to your request, except when you request that we not disclose information to your health plan about services for which you paid with your own money in full.
- Obtain a paper copy of this notice upon request.

You may make any of the above requests in writing to our office. You can reach Dr. Zachary Marshall at (682) 593-9355 or by email at info@dfwallergist.com. Please reach out to us with any questions.

Our Duties

We are required to provide you with notice of our legal duties and our privacy practices with respect to your health information. We must maintain the privacy of information that identifies you and notify you in the event your health information is used or disclosed in a manner that compromises the privacy of your health information.

We are required to abide by the terms of this notice. We reserve the right to change the terms of this notice and to make the revised notice effective for all health information that we maintain. We will post, and you may request, a copy of the revised notice. This notice is effective as of July 4, 2020 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect.

Complaints

Please reach out to us if you have any complaints, at (682) 593-9355. You have recourse if you feel your privacy protections have been violated. You have the right to file a written complaint with our office or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint. For more information about HIPAA and filing a complaint, contact: The U.S. Department of Health and Human Services, Office of Civil Rights, Independence Avenue, S.W., Washington DC 20201, (202)-619-0257 or toll free 1-877-696-6775.

Or please feel free to contact us for more information or questions, Phone: (682) 593-9355, Email: info@dfwallergist.com.

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PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

I, the undersigned, hereby understand that as part of my healthcare, DFW Allergist and Dr. Zachary W. Marshall originate and maintain health records describing my health history, symptoms, examination, test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers, and other routine healthcare operations including quality assessments and physician certifications. This Notice of Privacy Practices provides specific information and complete description of how my personal health information (PHI) may be used and disclosed. I have received and read a copy of the Notice of Privacy Practices, effective July 4, 2020 and understand that I have the right to review the notice prior to signing this authorization. I understand that I have the right to restrict the use and/or disclosure of my personal health information for treatment, payment or healthcare operations and that DFW Allergist and Dr. Marshall are not required to agree to the restrictions requested. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices. I may revoke this authorization at any time in writing except to the extent that Dr. Marshall has already taken action in reliance on my prior consent. This consent is valid until revoked by me in writing.

Please list family members or other persons, if any, whom may inquire and/or be informed about your general medical concerns/condition/diagnosis:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Other restrictions on the use/or disclosure of my personal health information:

_____

Patient Full Name (Printed): _____

Signature of Patient or Guardian: _____

Date of Signature: _____

Printed Full Name of Person Who Signed (if not Patient): _____

Relationship to Patient: _____

Witness (if applicable): _____