9821 South May Ave. Suite C
Oklahoma City, OK 73159

Phone: (405) 708-7876
Fax: (405) 259-5978

TAMBOLI
EYELID & FACIAL PLASTIC SURGERY

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

TREATMENT: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professions who may provide treatment or who may be consulted by staff members.

PAYMENT: Your health information may be used to seek payment from your health plan, from other sources or coverage such as an automobile insurer or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided and the medical condition being treated. You are required to provide this practice with all insurance coverage information, health, automobile and workers compensation (if applicable), or discuss and provide an alternative method for providing payment for services to this practice.

HEALTH CARE OPERATIONS: Your health information may be used as necessary to support the day-to-day activities and management of this practice. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

LAW ENFORCEMENT: Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections to facilitate law-enforcement investigation and to comply with government mandated reporting.

PUBLIC HEALTH REPORTING: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state’s health department.

OTHER USES/DISCLOSURES REQUIRING YOUR AUTHORIZATION: Disclosure of your health information or its use for any purpose, other than those listed above, require your specific written authorization. If you change your mind after authorizing a use or disclosure your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that has occurred prior to the date you notify us.

APPOINTMENT REMINDERS: Your health information will be used by our staff appointment reminders.

INFORMATION ABOUT TREATMENTS: Your health information may be used to send your information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and service

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that we believe may interest or be of benefit to you.

INDIVIDUAL RIGHTS: You have certain rights under the federal privacy standards. These include: • The right to request restrictions on the use and disclosure of your protected health information • The right to receive confidential communications concerning your medical condition and treatment • The right to inspect and copy your protected health information • The right to amend or submit corrections or your protected health information • The right to receive an accounting of how and to whom your protected health information has been disclosed • The right to receive a printed copy of this notice

THE DUTIES OF THIS MEDICAL PRACTICE: We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice. As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state law and regulations. Whatever the reason for the revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

REQUEST TO INSPECT INFORMATION: As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access by asking our receptionist or by contacting the Privacy Officer in writing.

COMPLAINTS: If you would like to submit a comment or complaint about our privacy practices, or suspect violations, you can do so by letter, outlining your concerns. Please address correspondence to the Privacy Officer, c/o this medical practice at our current address.

I am aware that my Protected Health Information will be used by Dr. Tamboli MD LLC and disclosed to others for the purposes of treatment (physician to physician or hospital), obtaining payment (insurance company) or supporting the day to day health care operations of the practice.

I have reviewed a copy of the Notice of Privacy Practices above.

I have reviewed the notice prior to signing this consent.
I am aware that I may request a restriction on the use or disclosure of my protected health information. If I should wish to restrict my disclosure, I should make the request in writing.

Please be aware that our practice, however, may or may not agree to restrict the disclosure of your protected information. If we agree to your request, the restriction will be binding.

Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of federal privacy standards.

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You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date of your revocation of consent is received will not be affected. This practice reserves the right to modify the privacy practices outlined in the notice.

I have reviewed this consent form and have reviewed the Notice of Privacy Practices.

I give my permission to this practice to use and disclose my health information.