

North Florida Dermatology Associates, P.A.
Laser and Cosmetic Surgery Institute

Board Certified in Dermatology and Dermatologic 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. Please review it carefully.

Our practice is dedicated to protecting your medical information. We are required by law to maintain the privacy of protected health information and to provide you with this Notice of our legal duties and privacy practices with respect to protected health information. Our practice is required by law to abide by the terms of this Notice.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment of health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Our office is required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at this time. Upon your request, we will provide you with any revised Notice of Privacy Practices. To request a revised notice you may call the office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment.

HOW YOUR MEDICAL INFORMATION WILL BE USED AND DISCLOSED

We will use your medical information as part of rendering patient care. For example, your medical information may be used by the doctor or nurse treating you, by the business office to process your payment for the services rendered and in order to support the business activities of the practice, including but not limited to, use by administrative personnel reviewing the quality of the care you receive, employee review activities, training of medical studies, licensing, contracting or arranging for other business activities.

We may also use and/or disclose your information in accordance with federal and state laws for the following purposes:

Appointment reminders: We may contact you to provide appointment reminders.

Treatment Information: We may contact you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Disclosure to Department of Health and Human Services: We may disclose medical information when required by the United States Department of Health and Human Services as part of an investigation or determination of our compliance with relevant laws.

Family and Friends: Unless you object, we may disclose your medical information to family members, other relatives or close personal friend when the medical information is directly relevant to that person (s) involvement with your care.

Notification: Unless you object, we may use or disclose your medical information to notify a family member, a personal representative or another person responsible for your care of your location, general condition or death.

Disaster Relief: We may disclose your medical information to a public or private entity, such as the American Red Cross, for the purpose of coordinating with that entity to assist in disaster relief efforts.

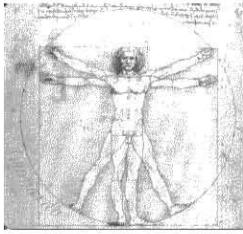
Health Oversight Activities: We may use or disclose your medical information for public health activities, including the reporting of disease, injury, vital events and the conduct of public health surveillance, investigation and/or intervention. We may disclose your medical information to a health oversight agency for oversight authorized by law, including audits, investigations, inspections, licensure or disciplinary actions, administrative and/or legal proceedings.

Abuse or neglect: We may disclose your medical information when it concerns abuse, neglect or violence to you in accordance with federal and state law.

Legal Proceedings: We may disclose your medical information in the course of certain judicial or administrative proceedings.

Law Enforcement: We may disclose your medical information for law enforcement purposes or other specialized governmental functions.

Coroners, Medical Examiners and Funeral Directors: We may disclose your medical information to a coroner, medical examiner or a funeral director.



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Providers

- Frank E. Schiavone, M.D.
- Robert G. Brown, M.D.
- Leonard A. Shvartzman, M.D.
- Jonathan Kantor, M.D.
- Sonia Espinoza, M.D.
- Michelle Sanson, P.A.-C
- Randolph B. Mahoney, P.A.-C
- Alice Beard, P.A.-C

NORTH FLORIDA DERMATOLOGY ASSOCIATES, P.A. HIPPA SIGNATURE AND AUTHORIZATION FORM

As of April 14, 2003 the Health Insurance Portability and Accountability Act of 1996 (HIPAA) has required us to provide you with our **Notice of Privacy Practices** which explains our privacy practices and how we may use and disclose your Protected Health Information (PHI) for treatment, payment, and for health care operations, as well as for other purposes that are permitted or required by law. For any other purpose we will notify the patient. Our office is dedicated to protecting the confidentiality of your Medical Records.

Our **Notice of Privacy Practices** also explains how the patient may obtain access and/or copies of their records, make specific requests pertaining to their records and the process to file a complaint if there are concerns about the privacy of their records.

We have posted **North Florida Dermatology Associates, P.A. Notice of Privacy Practices** in the Lobby for your review. It is important that you read this notice. You have the right to receive a paper copy of this notice. You may obtain a copy by asking our receptionist at your visit or by calling and asking us to mail you a copy.

Clinical Research Director

- Lisa Thomas, BS, CCRS

I have been given the opportunity to read the NFDA Notice of Privacy Practices and fully understand and accept the terms of this notice. A copy of this consent will be included in my chart for future reference.

Locations

- Riverside**
1551 Riverside Avenue
Jacksonville, FL 32204
- Baptist Pavilion**
836 Prudential Drive
Suite 1507
Jacksonville, FL 32207
- Orange Park**
1495 Kingsley Ave
Orange Park, FL 32073
- Beaches**
50 A1A North, Suite 103
Ponte Vedra Beach, FL 32082
- St. Augustine**
200 Southpark Boulevard
Suite 209
St. Augustine, FL 32086

Patient Name _____
Date of Birth

Patient or Representative Signature _____
Relationship to Patient _____
Date

___ I would like to specify as to other people who may fully participate in my health care needs on my behalf: Pick up prescriptions, make appointments, inquire about lab test results, etc.

Name of Individual (s) **Relationship** **Date of Birth**

_____ I would like to make further specifications regarding the use of my Protective Health Information (PHI).

Patient or Representative Signature **Relationship to Patient** **Date of birth**