NOTICE OF PRIVACY PRACTICES

To our patients: This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

USES AND DISCLOSURES: Use and disclosure of your health information in certain special circumstances maybe be required. The following circumstances may require us to use or disclose your health information without your consent:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information:

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to restrict our disclosure of your health to only certain individuals involved in your care or the payment for your care, such as family members and friends.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decision about you. You may ask us to amend your health information if you believe it is incorrect or incomplete. You have right to file a complaint. If you believe your privacy rights have been violated.

OUR DUTIES: Our facility is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

PRIVACY CONTACT: For more information about our privacy practices, please contact:

Privacy Officer
3347 State Rd 7, Suite 100, Wellington, FL 33449
Phone: 561 795 5558; Fax 561 792 7300

I hereby acknowledge that I have been presented with a copy of Notice of Privacy Practices of Independent Imaging .

Patient Name: _____ MRN: _____ Date: _____

Patient Signature: _____

If you are signing as the patient's representative:

Print your name: _____

Describe your authority: _____