Medicine by Manisha MD

MEDICINE BY MANISHA MD LLC
HIPAA INFORMATION AND CONSENT FORM

This form is provided in conjunction with our Notice of Privacy Practices (NPP), which is available at our office and at www.medicinebymanisha.com. Please review the NPP carefully.

The Health Insurance Portability and Accountability Act (HIPAA) protects the privacy and security of your Protected Health Information (PHI). HIPAA has been significantly updated by the HITECH Act (2009) and the Omnibus Rule (2013). This form summarizes how we handle your PHI and your rights. For complete information, visit **www.hhs.gov**.

HIPAA establishes rules governing who may access, use, or disclose your PHI. These rules do not restrict the normal exchange of information necessary to provide you with medical care. This form describes our policies and your rights. We are committed to providing high-quality, privacy-respecting care.

We have adopted the following policies:

1. Confidentiality and Use of Your Health Information

Your PHI will be kept confidential and used only as necessary to provide you with care, coordinate services with other providers, process billing, and fulfill administrative functions related to your care. We will use the **minimum necessary** PHI for each purpose, consistent with 45 CFR § 164.502(b).

Your medical records are maintained securely, and access is limited to authorized practice personnel involved in your care. PHI shared with other healthcare providers, laboratories, or other parties is done so only as necessary and appropriate for your care or as required by law.

2. Appointment Reminders and Communications

We may contact you to remind you of appointments or to provide information relevant to your care. We may use telephone, e-mail, text message, or U.S. mail. You have the right to request that we contact you using a specific method or at a specific location (e.g., only by email, only at a specific phone number), and we will accommodate all reasonable requests, consistent with 45 CFR § 164.522(b). We will not use your PHI for marketing or advertising without your separate written authorization.

3. Business Associates and Vendors

We work with third-party vendors who may have access to your PHI while providing services to the practice (such as billing, laboratory, IT, or records management).-All such vendors are required to execute a **Business Associate Agreement (BAA)**, which contractually obligates them to protect your PHI and use it only for the purposes for which it was disclosed. We do not permit vendors to use your PHI for their own marketing or other independent purposes.

4. Government and Regulatory Oversight

You acknowledge that government agencies (including the Department of Health and Human Services Office for Civil Rights, Florida Agency for Health Care Administration, and other authorized regulators) have the

legal authority to inspect practice records and review PHI as part of their oversight and enforcement duties. Such inspections do not require your consent and are permitted by law under 45 CFR § 164.512(d). Your PHI may also be disclosed as required by law, court order, subpoena, or government mandate.

5. Concerns and Complaints

If you have concerns or complaints regarding the privacy of your PHI, you may contact our Privacy Officer at: Medicine by Manisha MD LLC, 1111 SE Federal Hwy Suite 327, Stuart, FL 34994 | 772-245-0033 | info@medicinebymanisha.com. You also have the right to file a complaint directly with the U.S. Department of Health and Human Services, Office for Civil Rights (OCR), without fear of retaliation: **hhs.gov/ocr/privacy | 1-800-368-1019 | 200 Independence Ave SW, Washington, DC 20201.** You will not be penalized or retaliated against in any way for filing a complaint.

6. No Marketing Use of Your PHI

Your PHI will not be used for marketing, advertising, or the sale of products, goods, or services without your separate written authorization, consistent with 45 CFR § 164.508(a)(3). We will never sell your PHI. Any use of your PHI for marketing purposes requires your explicit, written authorization, which you may revoke at any time.

7. Access to Your Medical Records

You have the right to inspect, copy, and receive your medical records, consistent with HIPAA (45 CFR § 164.524) and Florida Statutes § 456.057. We will respond to access requests within 30 days. We may charge a reasonable, cost-based fee for copies. You also have the right to receive your records in electronic format if they are maintained electronically. You have the right to request amendments or corrections to your records. It is entirely up to us to accept or deny such request. We will respond to amendment requests within 60 days.

8. Changes to Our Policies

We reserve the right to amend our privacy policies and practices at any time in accordance with applicable law. Material changes will be communicated to active patients by written notice (email or mail) at least 30 days prior to taking effect, and the revised Notice of Privacy Practices will be posted in our office and on our website. You may request a copy of the current Notice at any time.

9. Your Right to Request Restrictions on Use of Your PHI

You have the right to request that we limit how we use or disclose your PHI. We will consider all such requests but are generally not required to agree. **EXCEPTION :** If you pay for a service entirely out-of-pocket and in full, you have the **right** to request that we not disclose PHI about that service to your health plan or insurer, and we are **legally required** to honor that request. This right is not discretionary. To exercise this right, please notify our Privacy Officer in writing at the time of service.

PATIENT CONSENT AND ACKNOWLEDGMENT

By signing below, I, _____, acknowledge that:

- I have received, read, and had the opportunity to ask questions about this HIPAA Information and Consent Form and the accompanying Notice of Privacy Practices.

Medicine by Manisha MD

- I understand how Medicine by Manisha MD LLC may use and disclose my PHI as described herein.
- I understand my rights regarding my PHI, including my right to request restrictions, access my records, receive an electronic copy, request amendments, receive an accounting of disclosures, and file a complaint.
- I consent to the uses and disclosures of my PHI described in this form for purposes of treatment, payment, and healthcare operations.
- I understand I may revoke this consent in writing at any time, and that revocation does not affect prior uses or disclosures.
- I understand this consent replaces and supersedes any prior HIPAA consent forms I may have signed with this practice.

Patient / Authorized Representative Signature | *Date*

Patient Printed Name | *Date of Birth*

Relationship to Patient / Authority (if Authorized Representative)