Direct Doctors
An Innovative Family Medicine Practice

2639 S County Trl
E Greenwich, RI
02818

Phone: (401) 400-2699
www.directdoctors.org
directdoctors@gmail.com

HIPAA Privacy Agreement

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.

YOUR RIGHTS

Get a copy of your medical records: You can ask to see or get a copy of your medical record at anytime. We will do this within 30 days of a request. We can release it directly to you with written notice from you or to another provider with your signed authorization from their office.

Ask us to correct your medical record: You can ask us to correct information about you that you think is incorrect or incomplete. We may say no, but if we do, we will notify you in writing within 60 days with our reasoning.

Ask us to limit what we use or share: You can ask us **not** to share certain health information for treatment, payment, or our operations. We are able to say "no" to your request but only if we deem it would affect your care. Because we do not bill insurance, we will not send information to your insurance company for payment unless the law requires us to share it.

Get a list of those with whom we've shared info: You can ask for a list of the times we've shared your information for six years prior to the date you ask, who we shared it with, and why.

Get a copy of this privacy notice: You can ask for an emailed copy of this notice at any time. If you prefer paper, let us know and we will give you that as well.

Choose someone to act for you: If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will check that that person has authority to act for you before we take action on their request.

File a complaint if you feel your rights are violated: You can complain if you feel we have violated your rights by contacting us (information below). You can file a complaint with the US Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C., 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
We will not retaliate against you for filing a complaint.

YOUR CHOICES

<u>You have the right to tell us how to share your information</u>:
Please list who you would like us to share medical information with (friends, family, caregivers, etc.) ____

____
We will only share with other healthcare providers directly involved with your care and those listed above. In an emergency situation, where you cannot give us information on your preferences, we will share with others only if we believe it is in your best interest. We may also share your information when needed to lessen a serious or imminent threat to health or safety.

<u>Email & Text Messaging</u>:

_________If you authorize Direct Doctors' to use **<u>non-secure email</u>** and **<u>non-secure text messaging</u>** to communicate with you, please initial

In initialing above, you acknowledge that:
- your "protected health information" (as that term is defined in the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and it's implementing regulations) will not be secured by cell phone and email communication which are not considered confidential or secure, and where there is always a possibility that a third party may gain access;
- you waive Direct Doctors' obligation to guarantee confidentiality with respect to correspondence via these means;
- cell & email communication can become part of the permanent medical record.

OUR USE AND DISCLOSURES

<u>We typically will share your private health information with</u>:
- Other healthcare professionals who are actively treating or evaluating you.
- Data analysts if we collect data on our practice in order to improve the care you receive.
- Life or disability insurance applications when we receive a signed authorization from you.

<u>PATIENT SIGNATURE</u>

____
Signing in acknowledgement of the above **Date**