WESLEY CHAPEL
INTERNAL MEDICINE AND PEDIATRICS

Acknowledgement of Receipt of

NOTICE OF PRIVACY PRACTICES

By signing this document, I acknowledge that I have received a copy of Dr. Shah's Notice of Privacy Practices.

Name (Please Print)	Signature	Date

If signing as a parent or guardian, please write the name of the patient below.

(minor or unable to sign)

FOR INTERNAL OFFICE USE ONLY

Date Acknowledgement received

Or

Reason Acknowledgement was not obtained:

Name (Please print)	Signature	Date

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Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

At our practice, we will always keep your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In case an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail your files for you.

You have the right to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for these copies.

You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier document, but will add new information.

You have a right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of health and Human service 200 Independence Avenue, S.W. , Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint.

However before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy officer, Dr Shah, phone number 813-929-3622.

This notice goes into effect as of the date on file.

Signature _____ Date _____

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PERMISSION TO DISCLOSE INFORMATION

Due to the Health Insurance Portability and Accountability Act (HIPPA) we are not allowed to disclose your health information to anyone without your written permission.

List names of those whom you want us to share your health information

Name	Relationship
_____	_____
_____	_____
_____	_____

Patient's Name _____
print name

Patient's Signature _____ Date _____