NOTICE OF PRIVACY PRACTICES AND PATIENT RIGHTS

Skin Cancer Center of S.E. Michigan, P.C.

Mark A. Stiff, M.D.

PURPOSE: THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. WE TAKE THE PRIVACY OF YOUR HEALTH INFORMATION SERIOUSLY.

OUR LEGAL DUTY: We are required by applicable Federal and State Law to implement policies and practices to maintain the privacy of your health information. We are also required to give you this Notice about our legal duties and privacy practices, and your legal rights concerning your health information. We must follow the privacy practices contained in this Notice while it is in effect. This Notice takes effect April 14, 2003 and will remain in effect until replaced.

We reserve the right to change our privacy practices and the terms of this Notice, effective for all health information we maintain, including health information we created or received before we made the changes, at any time, provided such changes are permitted by applicable law. Before making any significant changes in our privacy practices we will change this Notice and make it available upon request. You may request a copy of our Notice at any time. If you have any questions or concerns please contact us using the information at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION: We use and disclose health information about you for treatment, payment and health care operations. For example:

Treatment: We may use and/or disclose your health information to a physician or other health care provider providing treatment to you.

Payment: We may use and/or disclose your health information to obtain payment for the services you receive.

Healthcare operations: We may use and/or disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence and qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. Your consent may also be required in order for this office to make uses and disclosers regarding your health information if required by Michigan law.

With Your Authorization: We will not use or disclose your health information for any reason, except those described above, without your written consent. However, you may give written authorization to use and/or disclose your health information to any person for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any uses or disclosers made while the authorization was in effect.

Disclosure to Your Family and Friends: We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only under certain circumstances or if you consent to our doing so.

Disclosure to Persons Involved in Care: We may use or disclose health information to notify, or assist the notification of (including identifying or locating) a family member, your personal representative, or another person responsible for your care, of your location, general condition, or death. If you are present, then prior to the use or disclosure we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will exercise our professional judgment, disclosing only the information that is directly relevant to the person's involvement in your care. We will also use our professional judgment and experience with common practice to make reasonable inferences as to your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing: We will not use your health information for marketing communications without your prior written authorization.

Required By Law: We may use and/or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to the proper authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may also disclose your health information to the extent necessary to avoid a serious threat to your health or safety and the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose health information to a law enforcement official or correctional institution having lawful custody of inmate or patient under certain circumstances.

PATIENT RIGHTS

Access: You have the right to view or request a copy of your health information, with limited exceptions. You may request copies in a format other than photocopies. We will accommodate your request in the format you request, unless we cannot practicably do so. You must make the request for your records in writing. You can obtain a request form by contacting the person listed below as the Contact Officer. You may also request your records by sending a signed letter stating your request to the address below. We will charge you a reasonable fee for expenses such as staff time, copies, and postage. If you prefer, we will prepare a summary or an explanation of your health information for a fee. If you have questions regarding our fees please contact us using the information below.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operation and certain other activities, for the last six years, but not before April 14, 2003. If you request this information more than once in a twelve month period we will charge you a reasonable fee for the additional requests.
Restriction: You have the right to request we place additional restrictions on the use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement, unless there is an emergency.
Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.
Amendment: You have the right to request we amend your health information. Your request must be in writing and explain why we should amend your health information. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS: If you have questions or concerns, or would like more information regarding our privacy practices please contact us.

If you feel we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at an alternative location, you may complain to us using the information below. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint upon request.

We take the privacy of your health information seriously and respect your rights. We will not retaliate if you choose to file a complaint with us or the U.S. Department of Human Services.

CONTACT INFORMATION

Privacy Officer
c/o Skin Cancer Center of S.E. Michigan, P.C.
26400 W. Twelve Mile Road, Suite 180
Southfield, MI 48034
248-355-5047

RELEASE: You may identify someone you would like us to release your medical information to. Please indicate if there is someone whom you would like us to release your personally identifiable health information to:

Name: _____ Phone: _____

You may also identify someone to whom you specifically would like us to know you would not like information released to. Please indicate whom, if anyone, you would specifically like information restricted from:

Name: _____ Phone: _____

Please note that at any time you can change or withdraw this release or refusal to release or complete an entirely new release or refusal to release. If you would like to make a change please contact one of our office staff.

ACKNOWLEDGMENT: I acknowledge that the Skin Cancer Center of S.E. Michigan, P.C. has provided me with a Notice of my rights regarding my identifiable health information. I understand that it is my responsibility to review the Notice and that further guidance will only be given regarding this matter if I contact the Privacy Officer at the number above.

Dated: _____ /s/ _____