NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THIS NOTICE IS FROM BIJAN POURAT, M.D. INC., A PROFESSIONAL CORPORATION.

OUR COMMITMENT TO YOUR PRIVACY:
We are committed to maintaining your privacy. We will create records of your health information and the treatment and services we provide to you. We are required by law to maintain your privacy and to notify you of our legal duties and privacy policies. We reserve the right to advise or amend this Notice of Privacy Practices – the revised or amended notice will apply to all records created in the past or future. You may request a copy of our current Notice at any time.

WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS:

Treatment: We will use health information in the provision and coordination of healthcare. We may use and disclose your IIHI to treat you, by having laboratory tests done to make a diagnosis, or to order medications or supplements for you. We may disclose all or any portion of private health information, such as medical reports, to attending physicians and other health care providers who have a need for such information in your care and continued treatment. We may also disclose health information to other people, such as family members, who may be involved in your care.

Payment: We may use and disclose your IIHI in order to bill and collect payment for our services to you. We may use and disclose your IIHI to bill you or family members for our services

Health Care Operation: We may use and disclose your IIHI during routine healthcare operations including, without limitation, utilization review, evaluation of our staff, assessing the quality of care and outcomes in your case and similar cases, internal auditing, private health research and educational purposes.

Scheduling and Appointment Reminders: We may use and disclose your IIHI when scheduling medical or other healthcare services and when we contact you as a reminder of an appointment for services. We may also use and disclose private health information about treatment alternatives or other health-related benefits and services of possible interest to you.

Release of information to Family/Friends: We may release your IIHI to family or friends who are involved in your care. We may disclose this information in a disaster even over the patient's objection if we believe it is necessary to respond to the emergency circumstances. If our patient is unable or unavailable to agree or object, our healthcare professionals will use their best judgment regarding communication with the patient's family and others.

Disclosures Required by Law: We will disclose your IIHI when required to do so by federal, state, or local law or to assist law enforcement officials in their law enforcement duties.

Public Health: We may disclose IIHI to public health or legal authorities charged with preventing or controlling disease, injury or disability. For example, we may be required to report the existence of a communicable disease to the Department of Health to protect the health and well-being of the general public.

Regulatory Agencies: These include investigations, inspections, audits, surveys; civil, administrative and criminal procedures and actions; other activities needed for compliance with government programs, civil rights law, etc.

Judicial and Administrative proceedings: We may disclose your IIHI for law enforcement purposes as required by law or in response to a valid subpoena or court order.

Workers Compensation: We may release your IIHI for these programs.

YOUR RIGHTS REGARDING YOUR IIHI:

You have the following rights listed below. ("CFR" below stands for the Code of Federal Regulations). To exercise any of these rights, please contact the Privacy Officer identified below, in writing.

Right to Confidential Communication: You have the right to receive confidential communications of your IIHI by alternative means or alternative means or at alternative locations as provided by 45 CFR § 164.522. For example, you may request that we only contact you at work or by mail.

Right to Inspect and Copy: You have the right to inspect and copy your IIHI as provided by 45 CFR § 164.524.

Right to Amend: Your have the right to amend IIHI as provided by 45 CFR § 164.526.

Right to an Accounting: You have the right to receive an accounting or disclosures of your IIHI as provided by 45 CFR § 164.528.

Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of your IIHI as provided by 45 CFR § 164.522. PROVIDER may not agree to honor the request.

Right to Receive Copy of this Notice: You have the right to receive a paper copy of this notice, upon request.

Right to Revoke Authorization: You have the right to revoke your authorization to use or disclose your IIHI except to the extent that action has already been taken in reliance on your authorization.

FOR MORE INFORMATION OR TO REPORT A PROBLEM: If you have questions and would like additional information, you may contact: Nellie Seddigh, (Privacy Officer) at the number and address below. If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint please contact: Nellie Seddigh, 125 N. Robertson Blvd, Beverly Hills, CA 90211. All complaints must be submitted to the Privacy Officer in writing at the above address. There will be no retaliation for filing a complaint.

NOTICE EFFECTIVE DATE: The Effective date of the notice is June 1, 2014.

Patient Acknowledgement of Receipt of Notice of Privacy Practices

I HAVE BEEN PRESENTED WITH A COPY OF BIJAN POURAT M.D.'S NOTICE OF PRIVACY POLICIES, DETAILING HOW MY INFORMATION MAY BE USED AND DISCLOSED AS PERMITTED UNDER FEDERAL AND STATE LAW. I UNDERSTAND THE CONTENTS OF THE NOTICE, AND I REQUEST THE FOLLOWING PEOPLE (SPOUSE, PARENTS, ETC.) MAY ACCESS MY PERSONAL MEDICAL AND BILLING INFORMATION:

Further, I permit a copy of this authorization to be used in place of the original.

Signed:_____Date:_____

If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship:_____ Witnesses by:_____

Internal Use Only:

If patient or Patient's representative refuses to sign acknowledge of receipt of notice, please document the date and time the notice was presented to patient and sign below.

Presented on (date and time):_____

By (name and title):_____