MELISSA L. DELANEY, DO
Jacquelyn E. Mowday, CRNP
606 E. Marshall Street, Suite 205, West Chester, PA 19380
(610) 429-9101

NOTICE OF PRIVACY PRACTICES

The practice of Melissa L. Delaney, DO is required by both federal and state law to limit the manner in which it uses or discloses information about a patient or a patients health information. In addition, we are required to notify you of our legal obligations with respect to our privacy practices concerning your protected health information and to abide by the notice then in effect. Our employees and agents and the other health care professionals providing services to you in our office are subject to this notice.

Health information is broadly defined as any information whether oral or recorded in any form or medium that is created or received by this practice whether the information relates to your past, present or future physical or mental health or condition, the provision of health care to you, or the past, present or future payment for the provision of health care to you. Individually identifiable health care information is information that includes health information and also includes demographic information collected from you that identifies you or which reasonably can be used to identify you. This is generally referred to throughout this notice as protected health information or PHI. We are required by law to maintain the privacy of your PHI and to provide you with this privacy notice in effect from time to time.

If you are an existing patient, you have already signed consent. If you are a new patient, you will be asked to sign consent. The consent will allow our office to use and disclose your PHI for your treatment, to obtain payment for the services we render to you and to assist us in our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, and certification, licensing or credentialing activities. If you pay for a service in full and out of pocket, you can request that the office not disclose any information about that service to an insurance company with your written authorization to not do so. That written request has to be in writing and has to identify what information is restricted and what insurance company is not to receive it.

Your Authorization: In addition to our use of your health information or treatment, payment or health care operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice. Certain disclosures and uses of your health information require authorization from you, which can includ Psychotherapy notes, protected information that the office uses for marketing and any disclosure that the office makes that constitutes a sale for the protected information. You can choose to opt out of getting any fund raising communications from the office with your written authorization to do so.

To your Family and Friends: We must disclose your health information to you as described in the patients rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care, but only if you agree that we may do so. Any patients being treated under sedation must designate a responsible party to whom any health care information and post treatment care instructions can be disclosed.

Persons Involved in Care: We may use or disclose health information to notify or assist in the notification of a family member, your personal representative or another person responsible for your care, or your location, or your general condition, or death. If you are present, then prior to use or disclosure of your health information, 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 disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the persons involvement in your health care. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

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

We may use or disclose your health information when we are required to do so by law.

We may disclose your health information to appropriate authorities if we reasonably believe that you are a victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

We may disclose to military authorities the health information of the Armed Forces personnel under certain circumstances. We may disclose to the authorized Federal Officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

We may use or disclose your health information to provide you with appointment reminders.

Breach Notification: You will be notified in writing when a breach in your protected information occurs. Any loss or inappropriate disclosure of your health information is presumed to be a breach unless our office can show there is only a minimal probability the data will be used improperly.

PATIENT RIGHTS: You have the right to get copies or look at copies of your health information with limited exceptions. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the beginning of this notice. We will charge you a reasonable cost based fee for expenses and staff time. You have a right to receive a list of balances in which we or our business associates disclosed your health information for purposes other than treatment, payment, health care operations and certain other activities for the last 6months. If you request this accounting more than once in a 12 month period, we may charge you a reasonable cost based fee for responding to these additional requests.

You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these restrictions, but if we do, we will abide by our agreement (except in an emergency).

You have the right to request that we amend your health information. You must make sure your request is in writing and it must explain why the information is to be amended. We may deny your request under certain circumstances.

Questions and Complaints: If you want more information about our privacy practices or have questions, please contact us in person.

If you are concerned that we may have violated your privacy rights or 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 of disclosure of your health information or to have us communicate with you by alternative method, you may contact us any time.

We support your right to privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the US Dept of Health and Human Services.

Effective date of this privacy practice is September 5, 2013.

By signing the attached signature page of the HIPAA NOTICE OF PRIVACY PRACTICES for the Office of MELISSA L. DELANEY, DO, OB/GYN, YOU acknowledge that you have read and have been offered a copy of the aforementioned HIPAA Privacy Statement and YOU ARE authorizing Melissa L. Delaney, DO to leave results, if applicable on YOUR answering machine/voice mail/and or with the person(s) listed ON THE signature page of the Hipaa Notice of Privacy Practices.

IF YOU ARE UNDER 18 YEARS OF AGE, WE HAVE THE RIGHT TO DISCLOSE YOUR HEALTH INFORMATION WITH YOUR LEGAL PARENT OR GUARDIAN.

MELISSA L. DELANEY, DO

Jacquelyn E. Mowday, CRNP

606 E. Marshall Str, Suite 205, West Chester, PA 19380

(610-429-9101)

SIGNATURE PAGE (3) OF HIPAA NOTICE OF PRIVACY PRACTICES

I have read and have been offered a copy of the current **HIPAA NOTICE OF PRIVACY PRACTICES** : for the office of Melissa L. Delaney, DO OB/GYN which has been made available to me that explain **MELISSA L. DELANEY, DO, Ob/Gyn** privacy practices regarding my health information.

SIGNED:______________________________ date:__________
PRINT NAME:____

((Parent or Legal Guardian signature if patient is under 18yrs old)) :

___________________________________relationship:________
Print name:______________________________date:___________

Can leave message: **check all that apply**
( ) Answer machine/voice mail ( )Person(s)____________________
______________________ ____________________________

revised 09-04-13

MELISSA L. DELANEY, DO
OB/GYN

A current **HIPAA NOTICE OF PRIVACY PRACTICES**: has been made available to me and I have been offered a copy by Melissa L. Delaney, DO, Ob/Gyn of the **HIPAA NOTICE OF PRIVACY PRACTICES** that explain **MELISSA L. DELANEY, DO, Ob/Gyn** privacy practices regarding my health information.

SIGNED:_______________________________ date:__________

PRINT NAME:____