HIPAA Notice of
Privacy Practices

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.

ANCHORAGE RADIATION ONCOLOGY CENTER

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information:

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services, This includes the coordination or management of your health care with a third party, For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you, For example, your protected health information may be provided to a physician to whom you have been referred to ensure that they physician has the necessary information to diagnose and/or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students who see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call your by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and

National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights:

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, any protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must State the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment , you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your personal health information.

Complaints:

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against your for filing a complaint.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

This notice was published and because effective on/before April 14, 2003.

ANCHORAGE RADIATION ONCOLOGY CENTER

Receipt of HIPAA Information

Patient Name: _____

Date of Birth: _____

We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer at (907) 562-2002

Signature below is acknowledgement that you have received this Notice of our Privacy Practices.

Patient Name: _____ **Phone:**_____

Patient Signature_____ **Date:**_____

Legal Representative:_____ **Date:**_____

Relationship:_____

Authorizations for Release of Health Information

Please answer the following three questions regarding the release and disclosure of your medical and billing information. Return the completed form (signed and dated) to the front desk.

1. Do we, Anchorage Radiation Oncology Center, have your permission to release your medical information to ALL your healthcare providers and insurance companies? Y ☐ N ☐
2. Do we, Anchorage Radiation Oncology Center, have your permission to obtain you medical information from ALL of your healthcare providers and insurance companies? Y ☐ N ☐
3. Please list ALL family member(s)/guardian(s) that Anchorage Radiation Oncology Staff or physicians may speak with regarding your **C**are, **M**edical records, **F**inancial, and/or **B**illing information. Please list ALL:

Name	Relationship to Patient	Contact #	C	M	F	B
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐
			☐	☐	☐	☐

I have the right to revoke this authorization at any time. My revocation must be in writing, signed by me or my legal representative, and delivered to Anchorage Radiation Oncology Center, Attn: HIPAA Compliance Officer, via mail or in person. It will be effective only when Anchorage Radiation Oncology Center physically receives it. The information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Printed Patient Name _____ Patient's Date of Birth _____

Signature of Patient _____ Date _____

Signature of Client/Personal Representative _____ Relationship to Patient _____

Please note, this form expires one year after signed. You will be asked to complete this form annually.

ANCHORAGE RADIATION ONCOLOGY CENTER

Care Consent and Financial Policy

Patient Name: _____

Date of Birth: _____

I authorize you to give me reasonable and proper medical care by today's standards. All professional services rendered are charged to the patient, necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for fees, regardless of insurance coverage. It is also customary to pay for services when rendered unless other arrangements have been made in advance with Anchorage Radiation Oncology Center.

I request payment of authorized Medicare/Other Insurance company benefits be made on my behalf to Anchorage Radiation Oncology Center, for any services furnished me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier or any other insurance company any information needed for this or a related Medicare/Other Insurance company claim.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare /Other Insurance Company assigned cases, the physician agrees to accept the charge determination of the Medicare/Other Insurance Company as the full charge, and the patient is responsible only for the deductible coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Insurance Company.

Signature: _____ Date: _____