REGENT MEDICAL
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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT AND ACKNOWLEDGE BY SIGNING AT THE BOTTOM OF THIS PAGE.

The Health Insurance Portability & Accountability Ace of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant rights to control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

I understand that this information can and will be used for:

Treatment, payment and health care operations.

- Treatment means providing, planning and directing my health care and follow up among the multiple health care providers who may be involved in my treatment directly or indirectly.
- Payment means obtaining payment for third-party payer, such as insurance, patient or collection agencies. This would also include verifying insurance coverage.
- Health care operations include such quality assessments and any business aspect of running our practice.

We may also create and distribute de-identifiable health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminds or information about treatment alternative or other health related benefits or services that may be of interest to you.

I understand that I may revoke this consent in writing at any time, except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke It, Regent Medical may decline to provide treatment to me. Written requests are to be made to the address above.

PATIENT BILL OF RIGHTS

I understand that as a patient of Regent Medical I have the following rights:

1. Receive treatment with dignity, respect and consideration. I will not be subjected to, abuse, neglect, manipulation, sexual abuse/assault.
2. I will not be discriminated against based on race, national origin, religion, gender, sexual orientation, age, disability, marital status or diagnosis.
3. To receive treatment that supports and respects my individuality, choices, and abilities.
4. To receive privacy in treatment.
5. To review, upon written request, my medical records according to A.R.S. 12-2293, 12 2294, and 12-2294.01. There is a small fee for records that are printed for the patient.
6. To receive a referral to another health care provider if Regent Medical does not offer the services that I need.
7. To receive assistance from a family member, my representative, or other individual in understanding, protecting or exercising my patient rights.

PATIENT PRINTED NAME: _____ Date: _____

RELATIONSHIP TO PATIENT: _____

SIGNATURE: _____

Revised 12/15/22