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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.

We understand that health information about you and your health is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your right to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

Make sure that health information that identifies you is kept private Give you this Notice of our legal duties and privacy practices with respect to health information about you Follow the terms of the Notice that is currently in effect.

How we may use and disclose health information about you:

for treatment for payment for health care operations for appointment reminders as required by law public health risks health oversight activities lawsuits and disputes communicable disease abuse or neglect law enforcement inmates coroners, health examiners and funeral directors national security worker's compensation as required by the Military or Veterans to avert a serious threat to health and safety

Your rights regarding Health Information about you:

Right to inspect and copy Right to amend Right to an accounting of disclosures Right to request confidential communications Right to a paper copy of this Notice

Changes to this Notice:

We reserve the right to change this Notice. Upon your request we will provide you with any revised Notice

Complaints:

If you believe that your privacy rights have been violated, you may file a complaint with us or the Secretary of Health and Human Services.

We will provide a more detailed copy of these practices upon request.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Patient Signature

Date