Notice of Privacy Practices

Dr. Joel DiSanti

Uses and disclosures of your Health Information

Treatment: We will disclosure your health information to other health care workers for the purpose of treating you.
Payment: We will use and disclose your health information to obtain payment. This may include requests for information from insurance companies or other payers in relation to services rendered by us, or services rendered by other health care providers.

Uses and disclosures based on your authorization
You health care information will not be disclosed without your authorization.

Uses and disclosures Not requiring your authorization or approval
Health care training programs.
Provider accreditation, certification, licensing and credentialing activities.
For audits, legal services and medical reviews.
Business operations with in our practice, including general administration duties, services, planning and management.
Research purposes.
To medical providers involved in your care.
To family members and close friends involved in your care.
To communicate with you about health related products, services, and benefits.
Reminders such as appointment reminders
When required by law: court orders, subpoenas and other actions required the by law.
To law enforcement officials with regard to criminal activity an victims of crime.
Public safety: to report child or adult abuse, neglect, domestic violence and disease.
To government agencies as required for their oversight activities, investigations and audits.
Business associates that perform functions on our behalf. Business associates are required to protect the privacy of your health information.

Patient Rights
To examine and to receive a copy of your medical information.
You have the right to a list of certain disclosures where we disclosed your medical information.
To request that we amend your medical information.
You may request that we restrict our use or disclosure of your medical information.
You have the right to receive a copy of our privacy practices.
We will communicate with you about your medical information in confidence.

Acknowledgement of Receipt of Privacy Notice

I acknowledge I have been provided with or had the opportunity to read a copy of the privacy notice. I have had the opportunity to have any questions regarding this notice answered by my health care provider or members of his staff. If you are concerned that we may have violated your privacy rights please submit your concerns in writing to:

Dr. Joel DiSanti
2520 N. McMullen Booth Road, B304
Clearwater, FL 33761

If you are not satisfied with how our office handles your complaint, you may submit a formal complaint to:

Office for Civil Rights
U.S. Department of Health and Human Services
Sam Nunn Atlanta Federal Center, Suite 16T70
61 Forsyth Street, S.W.
Atlanta, GA 30303-8909

Date: _____ Time: _____

By: Print Patient's name: _____

Print Legal Guardians Name if Applicable: _____

Signature of Patient or Legal Guardian: _____