Advanced Practitioner Solutions LLC
13195 SW 134th Street, Unit# 102
Miami, Florida 33186

HIPAA NOTICE OF PRIVACY PRACTICES

Our office understands that health information about you is very personal and we are mandated by the Health Insurance Portability and Accountability Act (HIPAA) to protect your health information. We create a record of the care and services you receive from us, and this record helps to provide you with quality care and to comply with certain legal requirements. This HIPAA notice applies to all of the records of your care generated by us, and informs you about the ways in which we may use and disclose information about you. We also describe your rights 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 Healthcare operations
- For appointment reminders
- As required by law
- Public Health risks
- Health oversight activities
- Lawsuits and disputes
- Law enforcement
- To avert a serious threat to health and safety
- As required by the Military or Veterans and Workers Compensation
- Coroners, health examiners and funeral directors
- National Security and Intelligence activities
- Protective Services for the President and others
- Security Officials for Inmates

Your rights regarding Health Information about you:
- Right to inspect and copy
- Right to Amend
- Right to Accounting of Disclosures
- Right to Request Restrictions
- Right to Request Confidential Communication

Your medical records:
The original copy of your and/or electronic medical record is the property of our office. You may request a copy of your records to be transferred by completing a medical records release form. We require 14 business days from the date of your request to prepare and send your records unless the records are for urgent of life threatening health issues.

Changes to this notice:
We reserve the right to change this Notice. We will post a copy of the current notice in our facility with the current effective date.

Permission to share your health information:
We are required to follow certain federal guidelines and laws regarding the confidentiality of your personal health information. One of these prevents us from discussing anything in your medical file with anyone other than yourself or other medical personnel involved in your care. If you would like us to discuss lab results or other personal information with your significant other, family members, or any other individuals, please fill in their name and relationship to you in the section listed below.
Name(s):_____ Phone #
_____

Acknowledgement of receipt of the HIPAA Notice of Privacy Practices:
We request that you sign this form acknowledging you have received, read, and reviewed our HIPAA Notice of Privacy Practices. This acknowledgement will become part of your records. Thank you for your cooperation.

Printed Name of Patient _____

Signature of Patient ______________________________________ Date__________________________________