Notice of Privacy

To our patients: This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the **Health Insurance Portability and Accountability Act of 1996 (HIPAA).**

Our Commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special Circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court administrative order.
3. If required to do so by law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To Correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information:

1. **Communications:** You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable request.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by your agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **Taz Elizabeth Varkey, M.D. at 6310 San Vicente Blvd. Suite #290, Los Angeles, Ca 90048 Tel. (323) 933-2930 Fax. (323) 933-2948.**

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice to request amendment, your request must be made in writing and submitted to **Taz Elizabeth Varkey, M.D. 6310 San Vicente Blvd. Suite #290 Los Angeles, Ca 90048 Tel: (323) 933-2930 Fax: (323) 933-2948**. You must provide us with a reason that supports your request for Amendment.

5. Right to file a complaint: If you believe your rights have been violated, you may file a complaint with our practice or the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact **Taz Elizabeth Varkey, M.D. 6310 San Vicente Blvd. Suite #290 Los Angeles, Ca 90048 Tel: (323) 933-2930 Fax: (323) 933-2948**. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

6. Right to provide an authorization for other uses and disclosures: Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact **Taz Elizabeth Varkey, M.D. 6310 San Vicente Blvd. Suite #290 Los Angeles, Ca 90048 Tel: (323) 933-2930 Fax: (323) 933-2948.**

Taz E. Varkey, M.D.
Obstetrics and Gynecology
6310 San Vicente Blvd Suite # 290
Los Angeles, Ca 90048
Phone: (323) 933-2930 Fax: (323) 933-2948

I hereby acknowledge that I have been given a copy of Taz Elizabeth Varkey, M.D. Notice of Privacy Practices.

Signature:_____ **Date.**_____

Name of Patient: _____

Taz Elizabeth Varkey, M.D.
6310 San Vicente Blvd. Suite # 290
Los Angeles, Ca 90048
Phone: (323) 933-2930 Fax: (323) 933-2948

Patient Record of Disclosures

In general, the HIPPA privacy rule gives the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

Home Telephone: _____

- ☐ *Ok to leave message with detailed information*
- ☐ *Leave message with call back number only*

Work Telephone: _____

- ☐ *Ok to leave message with detailed information*
- ☐ *Leave message with call back number only*

Cellular Telephone: _____

- ☐ *Ok to leave message with detailed information*
- ☐ *Leave message with call back number only*

Written Communication

- ☐ *Ok to mail to my home address*
- ☐ *Ok to mail to my work/office address*
- ☐ *Ok to fax to this to this number* _____

If you would like to give our office permission to discuss your protected health information and your account/billing information with your spouse or any other individual, please list the names of these individuals here:

_____
_____
_____
_____

Other Instructions:

_____
_____

Patient Signature: _____ ***Date:*** _____

Print Name: _____ ***Date Of Birth:*** _____

Medical Record Number: _____

Taz Elizabeth Varkey, M.D.
Obstetrics, Gynecology and Infertility
6310 San Vicente Blvd Suite # 290
Los Angeles, Ca 90048
Phone: (323) 933-2930 Fax: (323) 933-2948

REGISTRATION FORM

Today's date: | Referring Physician:(if applicable)

PATIENT INFORMATION

Patient's last name: | First: | Middle: | ❑ Mr. ❑ Mrs. | ❑ Miss ❑ Ms. | Marital status (circle one) Single / Mar / Div / Sep / Wid

E-mail address: | PRIMARY CARE PHYSICIAN Name & Phone number: | Social Security number: | Birth date: / / | Age: | Sex: ❑ M ❑ F

Street address: | Cell phone number: ( ) | Home phone number: ( )

P.O. box: | City: | State: | ZIP Code:

Occupation: | Employer: | Employer phone no.: ( )

How do you prefer to receive your statements (please check one box): ❑ Fax ❑ E-Mail ❑ Mail

Who may we thank for your referral?

INSURANCE INFORMATION

Please give your insurance card to the receptionist.

IN CASE OF EMERGENCY

Name of local relative or friend (not living at same address): | Relationship to patient: | Home phone no.: ( ) | Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Taz Elizabeth Varkey, M.D. or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*