

**MARK VINCENT SOFONIO, M.D., F.A.C.S.**  
**BOARD CERTIFIED PLASTIC AND RECONSTRUCTIVE SURGEON**  
39000 Bob Hope Drive | Kiewit Building, Suite 407 | Rancho Mirage, CA 92270

## **NOTICE OF PATIENT PRIVACY RIGHTS AND CONSENT<sup>1</sup>**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. The Practice may use or disclose your protected health information to the extent that it is required by law. We also may use and disclose your health information without your consent or authorization. We have the right to refuse to treat you should you choose not to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time, you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent. Please review it carefully.

### **Your Rights**

- The Right to receive a copy of our “Notice of Privacy Practices”, which details how your health information may be used or disclosed by this organization.
- The Right to review or obtain a copy of your medical records your minor children, if you are the legal guardian.
- The Right to request restrictions on the use or disclosure of your medical records.
- The Right to receive your health information at an alternate address or through alternate delivery means, such as by fax, email or courier.
- The Right to request amendments or changes to your medical records, with certain limitations.
- The Right to get a list of those with whom we’ve shared your information
- The Right to file a privacy complaint directly with us, or with the federal government.
- The Right to choose someone to act for you
- The Right to receive a copy of this privacy notice

### **Your Choices**

**You have some choices in the way that we use and share information as we:**

- Tell family and friends about your condition, if you are present, and provide your consent
- Marketing our services and selling of your information
- Use and disclosure of psychotherapy notes
- Tell family and friends about your condition, if you are not present, in exercise of our professional judgement

### **Our Uses and Disclosures**

**Listed below are uses and disclosures are permitted or required by law:**

- Provide appropriate treatment for you and share with other health professionals as necessary
- Aid in emergency situations in which we need to render your care
- Assistance in disaster relief efforts, for purposes of coordinating your care with state or local relief services
- Run our organization as per scheduling, treatment, and communication with you
- Share with Business Associates (BAs) that undertake some essential administrating functions in the operation of this office
- Respond to research study’s applicable legal requirements if the practice is involved in such activities
- Bill for your services and share your health information to health plans, if necessary
- Respond to organ and tissue donation requests

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<sup>1</sup> HHS - <http://www.hhs.gov/ocr/privacy/hipaa/modelnotices.html>  
[www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html)

- Help with public health and safety issues as for disease prevention or other injuries and helping with recalls
- Respond to specialized Government Functions when authorized by law with regards to certain law enforcement, military and veteran activities
- Prevent abuse, neglect or domestic violence when authorized by law to provide information if we believe someone is at risk including reporting to Social Services or Protective Services Agencies.

**Our Responsibilities**

- Comply with the HIPAA Law as share health information with State and Federal Agencies
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it, if requested.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients’ consent for uses and disclosures of health information and for marketing purposes:

**Yes or No** \_\_\_\_\_ **(Initial)**\_\_\_\_ I consent for the office to leave messages on my messaging phone or cell.

**Phone # to be used** \_\_\_\_\_

**Yes or No** \_\_\_\_\_ **(Initial)**\_\_\_\_ I consent for the office to send me emails concerning my medical treatment.

**Email # to be used** \_\_\_\_\_

**Yes or No** \_\_\_\_\_ **(Initial)**\_\_\_\_ I consent for the office to send me emails concerning marketing purposes.

**Email # to be used** \_\_\_\_\_

The undersigned certifies that he/she has read the foregoing **Notice of Privacy Practices** and is the patient, or the patient’s personal representative. Copy is available upon request.

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Name of Patient

Signature of Patient

Date Signed: \_\_\_\_\_

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Name of Patient’s Personal Representative

Signature of Representative

Date Signed: \_\_\_\_\_

**Witness**

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Name of Employee

Signature of Employee

Date:

**Changes to the Terms of this Notice**

We reserve the right to revise or amend this Privacy Policy at any time. These revisions may be effective for all Protected Health Information (PHI) we maintain even if created or received prior to the effective date of the revision. The new notice will be available upon request, in our office, and on our website.

7/15/17