



Angela Yen Moore, M.D.

Board Certified Dermatologist
& Dermatopathologist

"Comprehensive Family Skin Care"

• Medical • Surgical • Cosmetic

email: acdermatology@yahoo.com

Todd O. Moore, M.D.

Board Certified
Colon & Rectal Surgeon

"Comprehensive Colon Care and Colonoscopy"

Specializing in Colonoscopy, Hemorrhoid Treatment,
and Colorectal Surgery

email: aricolorectal@yahoo.com



Phone: 817-795-7546

Fax: 817-226-7546

711 E. Lamar Blvd. Suite 200 • Arlington, Texas 76011

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 CARE FULLY.

The Health Insurance Portability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, or paper, or orally, are properly confidential. The Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more providers.
- Payment means such activities as obtaining reimbursements for services, confirming coverage, billing and collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example of this would be an internal quality assessment review.

We may also release confidential medical information to your insurance carriers, to review and assess your insurance, reimbursement, and coverage for office visits and related procedures. We may release confidential medical information to your insurance carriers and their employees that we contact on your behalf, for this purpose. Such information may include your name, age, sex, medical diagnosis, insurance identifiers, employers, or medical providers you identify.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other uses and disclosures will be made with only your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

- The right to request restrictions on uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

I acknowledge that I have read and agree to be bound by the terms and office policies stated above in areas of Notice of Privacy Practices. The duration of this authorization is indefinite or until it is revoked in writing.

Patient Signature

Date