



Volunteers in Medicine West County Clinic
14395 Manchester Road
Manchester, MO 63011
636-207-5970
www.vimwestco.org

Contact Preferences

In general, the HIPAA privacy rule gives individuals 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 be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

Please check the boxes next to each method of communication you would like us to use:

Home

- OK to leave message with detailed information
- Leave message with call-back number only
- OK to mail

Work

- OK to leave message with detailed information
- Leave message with call-back number only
- OK to mail
- OK to fax

Cell phone

- OK to leave message with detailed information
- Leave message with call-back number only

Other:

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. Please see the accompanying Notice of Privacy Practices for more information on our policies. Please list any individuals among your friends, family, or caretakers with whom we are authorized to discuss your protected health information. You should write your spouse's name here if he/she is authorized. This is optional; if you do not wish us to discuss your PHI with anyone but yourself and your healthcare providers please leave this blank:

Name	Phone Number	Relationship

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices.

Signature of Patient or Personal Representative

Today's Date



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Authorization Form Release of Confidential Health Information

I, _____, hereby authorize _____ to release to:

(Name of Patient of Authorized Agent)

(Name of Physician)

(Name of Health Care Facility, Physician, Agency, etc.)

(Street Address, City, State, and Zip Code)

the following information contained in the patient record of _____
(Patient's Name)

born _____ / _____ / _____, residing at _____
(Month, Day, Year) (Street Address, City, State, and Zip Code)

- The entire medical record, excluding mental health treatment, alcoholism treatment, drug abuse treatment, and HIV/acquired immune deficiency syndrome (AIDS) records

To be disclosed, the following items must specifically be checked:

- Mental Health Treatment Records
 Alcoholism Treatment Records
 Drug Abuse Treatment Records
 HIV/Acquired Immune Deficiency Syndrome (AIDS) records
 Laboratory Reports
 X-Ray Reports
 Operative Notes
 Genetic Testing
 Other: _____

The above information for the following period of time shall be released:

From: _____ to _____
(Date) (Date)

The purpose(s) of the authorization is (are) _____

I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above described information, I understand that it will not be disclosed, except as provided by law.

I understand that the practice may not condition treatment on whether I sign this authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosed to a third party.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by law.

I understand that this authorization is valid until it expires, unless revoked before that.

I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information. Written revocation must be sent to the physician's office.

Signed: _____

Date: _____

If you are not the patient, please specify your relationship to the patient: _____



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Privacy Practice Notice Patient Copy

Notice available upon request beginning on the revision's effective date. The revised notice is posted in the practice's reception area and made available to all patients, including those who have received a previous Notice. Upon receipt of a revised Notice, a patient is asked to acknowledge receipt of the Notice.

Complaints: The practice allows all patients and their agents to file complaints with the practice and with the Secretary of the Federal Department of Health and Human Services (DHHS). A patient or his or her agent may file a complaint with the practice whenever he or she believes that the practice has violated their rights.

Complaints to the practice must be in writing, must describe the acts or omissions that are the subject of the complaint, and must be filed within 180 days of the time the patient became aware or should have become aware of the violation. Complaints must be addressed to the attention of the practice's privacy office at the practice address. The practice investigates each complaint and may, at its discretion, reply to the patient or the patient's agent.

The practice does not take any adverse action against any patient who files a complaint (either directly or through an agent) against the practice.

Contact Person: The practice has a privacy officer that serves as the contact person for all issues related to the Privacy Rule. If you have any questions about this Notice, please contact our privacy officer at (636)207-5970 or by mailing it to VIM West County Clinic Attention: Privacy Officer – 14395 Manchester Road Manchester, MO 63011.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

The practice reasonably ensures that the protected health information (PHI) it requests, uses, and discloses for any purpose is the minimum amount of PHI necessary for that purpose.

The practice treats all qualified individuals as personal representatives of patients. The practice generally allows individuals to act as personal representatives of patients. The two general exceptions to allowing individuals to act as personal representatives relate to the unemancipated minors and abuse, neglect, or endangerment situations.

The practice makes reasonable efforts to ensure that protected health information is only used by and disclosed to individuals that have a right to the protected health information. Toward that end, that the practice makes reasonable efforts to verify the identity of those using or receiving protected health information.

Uses and Disclosures – Treatment, Payment, and Health Care Operations

The practice uses and discloses protected health information for payment, treatment, and health care operations. Treatment includes those activities related to providing services to the patient, including releasing information to other health care providers involved in the patient's care. Payment relates to all activities associated with getting reimbursed for services provided.