# Legacy Surgery Center

6918 Gunn Highway, Suite E. • Tampa, Florida 33625 • Phone 813-852-2500 • Fax 813-852-2541

## NOTICE OF PRIVACY PRACTICES Describing How Medical Information About You May Be Used and Disclosed And How You Can Get Access to this Information. Please Review Carefully.

At Legacy Surgery Center, we will always keep your health information secure and confidential. The Health Insurance Portability and Accountability Act requires us to maintain your privacy, to give you this notice and to follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment. For example, reviews of your file by a specialist doctor whom we may involve in your care. We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer. We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law. If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

- You have the right to transfer copies of your health information to another practice. We will mail your files for you. You have a right to receive a copy of your health information, with a few exceptions. Please provide us with a written request regarding the information you want to have copied, however, we may charge you a reasonable fee for the copies.
- You have the right to request and amend your health information. Please provide us with your request to make changes in writing. If you wish to include a statement in your file, please provide it to us in writing. We may or may not make the changes that you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will neither move nor alter earlier documents, but will add new information.
- You have the right to receive a copy of this notice at any time upon request. If we change any details of this notice we will notify you in writing.
- You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, Washington, D.C.2020 I. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer: Carolyn Beatty (813) 955-6437. This notice went into effect on July 18, 2018.

**[ ]** ***Acknowledgement:*** **I have read, understand, and agree with the above Notice of Privacy Practice.**

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Patient's Signature Date Witness to Patient's Signature Date

If patient is unable to sign or is a minor, please sign below.

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Relative or Legal Guardian Signature Date Witness to Relative/Guardian Signature Date