

## PRIVACY PRACTICE POLICY



This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

American Medical Center is committed to preserving the privacy and confidentiality of your health information that is created and maintained at our clinic. This describes the ways in which we may use or disclose your health information and also describes your rights and our obligations concerning such uses or disclosures.

The privacy practices described will be as follows,

Any health care professional authorized to enter information into your medical record created and maintained at our clinic,

All employees, students, residents and other service provider, who have access to your health information at our clinic,

Or any member of a volunteer group that is allowed to help you while receiving services at our clinic.

The individuals identified above will share your health information with each other for purposes of treatment, payment, and health care operations as further described in the notice.

### **Uses and disclosures of health information for treatment payment and health care operations.**

Treatment - We may use your health information to provide you with health care treatment and services. We may disclose your health information to doctors, nurses, nursing assistants, technicians, medical and nursing students, rehabilitation therapy specialists or other personnel who are involved in your health care.

Payment – We may use or disclose your health information so that we may bill and receive payment from you, an insurance company or another third party for the health care services you receive from us. We may also disclose health information about you to your health plan in order to obtain prior approval for the services we intend to provide to you, or to determine that your health plan will pay for treatment.

Healthcare Operations – We may use or disclose your health information in order to perform the necessary administrative, educational, quality assurance, and business functions of our clinic.

### **Uses and disclosures of health information in special situations.**

We may disclose your health information for purposes of contacting you to remind you of a health care appointment.

We may use or disclose your health information for purposes of contacting you to inform you of treatment alternatives or health related products or services that may be of interest to you.

We may disclose your health information to individuals, such as family members and friends who are involved in your care or who help pay for your care. We may make such disclosures when:

We have your verbal agreement to do so,

We make such disclosures and you do not object,

We can infer from the circumstances that you would not object to such disclosures.

We may disclose health information when authorized or necessary to comply with laws relating to workman's compensation or other similar programs.

As required by law, we may disclose your health information when required by federal, state or local law to do so without your consent.

We may disclose your health information to public health authorities that are authorized to receive and collect health information for purposes of preventing or controlling disease, injury or disability, to report birth deaths, suspected abuse or neglect, reactions to medications or to facilitate product recalls without your consent.

We may disclose your health information in response to a request received from a law enforcement official to report criminal activity or to respond to a subpoena, court order, warrant, summons or similar process.

**You have a right to:**

Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may ask the receptionist for the form needed to request access.

There may be charges for copying and for postage if you want the copies mailed to you. Ask the receptionist about our fee structure.

Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment and health care operations and other specified exceptions.

Request that we communicate with you about your medical information by different means or to different locations.

Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.

If you wish to receive a paper copy of this notice, then you have the right to obtain a paper copy by making a request in writing to our Privacy Officer.

If you have any questions about this notice, please ask the receptionist to speak to our Privacy Officer. If you think that we may have violated your privacy rights, you may speak to our Privacy Officer and submit a written complaint.

If you have any questions regarding this notice or believe that your privacy rights have been violated, please contact:

Hoa Van Nguyen, MD  
American Medical Center  
1244 N. Marine Corps Drive  
Upper Tumon, GU 96913  
Tel: (671) 647-8262  
Fax: (671) 647-8257



All complaints/requests must be submitted in writing.



## ACKNOWLEDGEMENT OF PRIVACY PRACTICE POLICY

I, \_\_\_\_\_, acknowledge that I have received a copy of American Medical Center's Privacy Practices.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name (Legal Representative if Minor)

\_\_\_\_\_  
Relation to Patient

\_\_\_\_\_  
Signature of Legal Representative

\_\_\_\_\_  
Date