NOTICE OF PRIVACY POLICIES

FOR

Las Colinas Obstetrics Gynecology Infertility Association, P.A.

Revision Number _____

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

At Las Colinas Obstetrics Gynecology Infertility Association, P.A., we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit Las Colinas Obstetrics Gynecology Infertility Association, P.A., a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating heath professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve,

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others

Your Health Information Rights

Although your health record is the physical property of Las Colinas Obstetrics Gynecology Infertility Association P.A., the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Las Colinas Obstetrics Gynecology Infertility Association, P.A. is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us, or if you agree, we will email the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If have questions and would like additional information, you may contact the practice's Privacy Officer, Our Office Manager, Nina Salinas (972) 869-4488 ext. 111

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Examples of Disclosures for Treatment, Payment and Health Operations

IV. Obsterical History # of pregnancies:_____ # of children:_____ # miscarriages/abortions:_____

	Date of Delivery	Type of Delivery	Pregnancy Complication
1.			
2.			
3.			
4.			

V. Review of Systems

- How many hours per week do you exercise? _____
- What type of exercise? _____
- Do you have any significant weight gain or loss over last year?..... Yes No
  Please describe:_____
- Do you frequently feel tired, lack of energy, sleep, or depressed? (Please Circle)..... Yes No
  Please describe:_____
- Do you have any discharge from your breast:..... Yes No
- If yes, from which breast?_____ , amount_____ , color_____ .
- Do you have excessive facial or body hair?..... Yes No
- Do you shave your face? How often a week?_____
- Do you have a problem with acne?..... Yes No

VI. Blatter and Bowel Syptoms

- Do you have any problems with urination such as: frequency, pain, or sence of urgency? (Please Circle)..... Yes No
- Do you leak urine when you exercise of cough?..... Yes No
- Do you have to wake up to go to bathroom at night..... Yes No
- How many times a night?_____
- Has there been any change in your bowel habits (diarrhea, constipation, irritable stomach)?..... Yes No
- Do you have pain durring bowel movement?..... Yes No
- Do you notice any blood in the stool?..... Yes No

VII. Family Medical History

Has anyone in your immediate family (mother, father, sister, brother, aunts, uncles, ect.) ever had.....

- Birth Defects Who? _____ Yes No
- Genetic Diseases Who? _____ Yes No
- Cancer of Breast Who? _____ Yes No
- Cancer of Uterus or Overy Who? _____ Yes No
- Cancer of Colon Who? _____ Yes No
- Diabetes Who? _____ Yes No
- High Blood Pressure Who? _____ Yes No
- Heart Disease Who? _____ Yes No

VIII. Partner's Profile

- Has he fathered any children?_____ How many?_____ Age of youngest child?_____
- Does he have any significant illness (including childhood mumps)?..... Yes No
  Please specify:_____
- Does he take any medication?_____
- Has he ever had injury to the groin?..... Yes No
- Has he ever had male surgery (ie. prostate surgery, vasectomy)?..... Yes No
- Does he smoke?_____ Drink alcohol?_____
  Recreational drug? (marijuana, cocaine, amphetamine, ect.)_____
- Has he had prior exposure to radiation or chemical toxins?..... Yes No
  Please specify:_____