

JOHN H. ALEXANDER, M.D., F.A.C.S.

11970 NORTH CENTRAL EXPRESSWAY, SUITE 600

DALLAS, TX 75243

PH: 972-347-7767 FAX: 972-247-6268

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 carefully. Dr. Alexander and his staff maintain your medical information in a confidential manner, as required by law. However, this office must share the information, as necessary to carry out treatment and provide you with quality healthcare.

Unless you ask for restrictions, your medical information may be used to disclose the following purpose:

- 1 To provide you with appointment reminders.
- 2 Use in the hospital.
- 3 To carry out payment, healthcare, operations or other functions through business associates.
- 4 Health oversight activities (audits, inspections, investigations)
- 5 Lawsuits and disputes.
- 6 Medical Examiners.
- 7 To prevent a serious threat to health or safety.
- 8 To military command authorities if you are a member of the armed forces.
- 9 National security and intelligence activities.
- 10 Protection of the President or other authorized persons of foreign heads of state, or to conduct special investigations.
- 11 As required by law.

Your authorization is required for other disclosures. Except as described above, your medical information will not be used or disclosed unless you provide written authorization to disclose it. You may revoke your authorization, which will be effective only after the date of written revocation.

You have the rights to you medical information. To invoke any of the following rights, you must make a written request on the form provided by Dr. Alexander's office.

- 1 Right to request restrictions.
- 2 Right to confidential communications.
- 3 Right to inspect and copy.
- 4 Right to request amendment.
- 5 Right to accounting of disclosure.
- 6 Right to a copy of this notice.

Dr. Alexander's office is required by law to maintain the privacy of medical information and to provide you with the notice of our legal duties and privacy practices with respect to medical information.

If you believe your rights have been violated, you may file a complaint with Dr. Alexander's office or with the Secretary of the United States Department of Health and Human Services. You will not be penalized or retaliated against in any way for making a complaint.

- 1 You have a privacy complaint.
- 2 You have any questions about this notice.
- 3 You wish to request restrictions.
- 4 You wish to obtain a form to exercise you rights as described above.

Patient's Signature
Witness Initials

Date

Printed Patient's Name