

Goldman Vein Institute  
3535 Military Trail, Suite 204  
Jupiter, FL 33458  
NOTICE OF PRIVACY PRACTICES

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**

This Joint notice of Privacy practices is being provided to you on behalf of Goldman Vein Institute, with the respect to vein disorders medical services provided at Goldman Vein Institute facilities (collectively referred to herein as “We” or “Our”). We understand that your medical information is private and confidential. Further, we are required by law to maintain the privacy of “protected health information.” Protected health information includes any individually identifiable information that we obtain from you or others that relates to your past, present or future physical or mental health, the health care you have received, or payment for your health care.

**Your Rights**

Although your health record is the physical property of Goldman Vein Institute, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information as provided by applicable law.
- Obtain a paper copy of the notice of information practices upon request.
- Inspect and copy your health record as provided for by applicable law.
- Request to amend your health records as provided by applicable law.
- Obtain an accounting of disclosures of your health information as provided by applicable law.
- Request communications of your health information by alternative means or at alternative locations.
- Revoke your authorizations to use or disclose health information except to the extent that action has already been taken.

**Our Responsibilities:**

We are required to:

- Maintain the privacy of your health information
- Provide you with a 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
- Accommodate reasonable request 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.

We will not use or disclose your health information without your authorization, except as described in this notice.

### **Permitted Uses and Disclosures**

*We will use your health information for treatment. For example:* information obtained by a nurse, physician or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your Physician will document in your records his expectation of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way the physician will know how you are responding to treatment.

We will also provide your physician or subsequent healthcare provider with copies of various reports that should assist him/her in treating you once you're discharged from this practice.

*We will use your health information for payment. For Example:* A bill may be sent to you or a third party payor, such as an insurance company or health plan, for the purposes of receiving payment for treatment and services that you receive. The information on the bill may contain information that identifies you, your diagnosis, and treatment of supplies used in the course of treatment.

*We will use your health information for regular health operations. For example:* Members of the clinical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality Goldman Vein Institute and effectiveness of the healthcare and the reproductive medicine service we provide.

### **Other Uses or Disclosures of Protected Health Information**

***Business Associates:*** There are some services provided as Goldman Vein Institute, through contacts with business associates. For example: the management services of Goldman Vein Institute, certain laboratory, tests and collection services. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we have asked them to do and bill you or your third party payer for services rendered. So that your health information is protected, however, we require the business associate to appropriately safeguard your information.

***Appointments:*** \_ we may use or disclose your health information to contact you to remind you of an appointment.

***Notification:*** We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

***Communication with Spouse/Family:*** Health professionals, using their best judgment, may disclose to your spouse, family member, or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care. If you are not at home, we may leave this information on your answering machine or in a message left with the person answering the telephone. We will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object.

***Research:*** We may disclose information to researchers when their research has been approved by an Institutional Review Board that has reviewed the research proposal and establishes protocols to ensure the privacy of your health information. In most cases, we will identify your patient information so that others can use the de-identified information to study reproductive healthcare and health care delivery without learning who you are.

***Marketing:*** We may contact you to tell you about or recommend possible treatment alternatives or other venous medical technology and services that may be of interest to you.

**Food and Drug Administration (FDA):** We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product defects or post marketing surveillance information to enable product recalls, repairs or replacement.

**Public Health:** As required by law, your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, disability or for other health oversight activities.

**Law Enforcement:** We may disclose health information for law enforcement purposes as required by law, or in response to valid subpoena. Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a workforce member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

**Note: HIV –related information, genetic information, mental health records and other specially protected health information may be subject to certain special confidentiality protections under applicable state and Federal Law. Any disclosures of these types of records will be subject to these special protections.**

**For More Information or to Report a Problem /Complaint**

If you believe your privacy rights have been violated, if you have any questions or would like further information you should contact:

**Goldman Vein Institute, 3535 Military Trail, Jupiter, Florida 33458, Telephone (561)741-1043**

We will not take action against you for filing a complaint. You may also file a complaint with Secretary of Health and Human Services.

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This is to acknowledge that I have received a copy of the Notice of Privacy Practices of Goldman Vein Institute.

Name: \_\_\_\_\_ Patient Chart Number: \_\_\_\_\_  
(Please Print)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Disposition: File this Acknowledgement Form in the Patient’s medical Record.**