

HIPPA Notice of Privacy Practices Effective Date 9/23/2013

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

RICHMOND NEPHROLOGY ASSOCIATES

671b Hioaks Road, Richmond, Virginia 23225
5875 Bremono Road, Suite 311, Richmond, Virginia 23226
Memorial Regional MOB II, 8266 Atlee Road, Suite 322, Mechanicsville, Virginia 23116
15151 Patrick Henry Highway, Amelia, Virginia 23002
611 Watkins Centre Parkway, Suite 200, Midlothian, Virginia 23112

804-272-5814

Privacy Officer: Judith Maly, Administrator (804)272-5814
671b Hioaks Road, Richmond, Virginia 23225

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends.
- Provide disaster relief
- Market our services and sell your information

Other Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation request and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government request
- Respond to lawsuits and legal actions

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES:

I hereby acknowledge that I have received a copy of the practice's **Notice of Privacy Practices**. I have had an opportunity to read the Notice of Privacy Practices and understand that I may ask questions to the medical practice if I do not understand any information contained in the Notice of Privacy Practices.

Patient or Representative Name (Please Print)

RNA #

Patient or Representative Signature

Date