AVEDAMED®
Primary Care | Cardiology | Rheumatology

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PATIENT PRIVACY NOTICE

I, _____, acknowledge that I have been provided with and understand this Notice of Privacy Practices from AvedaMed, LLC, and its affiliated providers and staff (hereinafter referred to as "Practice"). This Notice describes how my medical information may be used and disclosed, and how I may access this information.

Use and Disclosure of Protected Health Information: The Practice may use and disclose my Protected Health Information (PHI) without my written authorization for purposes of treatment, payment, and healthcare operations. This includes coordination of care between providers, submission of insurance claims, billing activities, quality improvement initiatives, and administrative operations necessary to run the Practice. The Practice may also disclose my PHI when required by law, including for public health reporting, law enforcement requests, or regulatory compliance.

Minimum Necessary Standard: The Practice will limit the use, access, and disclosure of my PHI to the minimum amount necessary to accomplish the intended purpose. Access to my information is restricted based on staff roles and responsibilities.

Patient Rights: I understand that I have the right to access and obtain a copy of my medical records, request amendments to my health information, request restrictions on certain uses or disclosures, request confidential communications, and receive an accounting of disclosures of my PHI. I also have the right to file a complaint if I believe my privacy rights have been violated, without fear of retaliation.

Safeguards and Security Measures: The Practice maintains administrative, physical, and technical safeguards to protect my PHI. These include secure electronic systems, password protection, controlled access to records, staff training, and proper disposal of sensitive information. The Practice prohibits unauthorized discussions or sharing of PHI in public or unsecured environments.

Communication and Electronic Use: The Practice may communicate with me via phone, voicemail, email, or other methods provided by me. I understand that standard email or text messaging may not be fully secure, and I accept this risk unless I request alternative communication methods in writing.

Breach Notification: In the event of a breach involving my unsecured PHI, the Practice will notify me in accordance with applicable federal and state laws and will take appropriate corrective action.

Acknowledgment and Updates: I acknowledge that I have received this Notice of Privacy Practices and understand that the Practice reserves the right to update or modify this Notice at any time. Updated versions will be made available upon request and at the Practice location.

Signature: _____ **Date:** _____