Compassionate Care for Women

Lawson C Richter, MD

Privacy Practice Notice
HIPAA

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

All requested information should be relevant to the care and well being of the individual served. All information should be considered Protected Health Information (PHI), in accordance with the Federal Health Insurance Portability and Accountability Act (HIPAA) of 1996.

Signature of this Privacy Notice shall serve as acknowledgment that **Lawson C Richter, MD** may use and/or share information for treatment, payment and overall healthcare operations that may include counseling, billing and quality assurance. The use or sharing of any information not directly related to services and support shall have prior authorization.

An example of sharing information that maybe necessary without written consent or authorization is a life threatening medical emergency.

Rights of the Individual
The individual, in writing may request restrictions on the use or sharing of any information, received confidential communication, inspect and receive copies of shared information, receive an accounting of shared information and amend or revoke authorization.

Duties of Covered Entity
Maintain Privacy and provide notice of legal duties and privacy practice. Abide by this effective notice and any restriction agreements. Provide notice of revised privacy practices.

For additional information or complaints regarding privacy practices contact the HIPAA Compliance Officer at 702-471-0015 ext. 229.

Complaints against **Lawson C Richter, MD** regarding privacy of PHI.
Please forward to:

Lawson C Richter, MD
601 S Rancho Dr Suite D34
Las Vegas, NV 89106

This notice has been issued and considered effective: ______________________________

Lawson C Richter, MD shall retain this copy for a minimum of six (6) years.

______________________ Print Patient Name	____________________ Date
______________________ Patient Signature	______________________ Guardian if Patient under 18
______________________ Witness (CCFW employee)	____________________ Date