HIPPA Notice of Privacy Practices

Delaware Medical Care Associates, LLC

Your information. Your rights. Our responsibility.

If you have any questions about this HIPPA Notice or want a copy please contact our privacy officer:
Fran Miller at fsheftz@comcast.net or 302-633-9033 Ext 109

Your Rights

- Get a copy of your paper or electronic medical record
- Request confidential communication
- Get a list of those with whom we have shared your information
- File a complaint if you believe your privacy rights have been violated
- Correct your paper or electronic medical record
- Ask us to limit the information we share
- Choose someone to act for you

Your choices

- Tell family and friends about your condition
- Include you in a hospital directory
- Market our services and sell your information
- Provide mental health care

Our Uses and Disclosures

- Run our organization successfully while also treating your health
- Help with public health and safety issues
- Comply with the law and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Bill for your services
- Respond to lawsuits/legal actions

Our Responsibilities

- We are required by law to maintain privacy and security of your protected health information
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information
- We must follow the duties and privacy practices described in this notice and give you a copy of it
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time by having something in writing.

Changes to the terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

My signature below: Acknowledges I have read the HIPPA Notice of Privacy Practices provided to me by Delaware Medical Care Associates, INC. I have been given the opportunity to have any questions I might have answered and I understand the statements contained in both. A copy of this page will be maintained in my records for as long as Delaware Medical Care Associates, LLC maintains my records.

My signature below: Consents Delaware Medical Care Associates, INC for purposes of diagnosing or providing medical treatment to me; Also obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment may be conditioned upon my consent as evidenced by my signature on this document.

Patient/Representative Signature_____ Date_____

Revised 06/2023