Ablon Skin Institute
1600 Rosecrans Ave Bldg 4B
Manhattan Beach, Ca. 90266
310-727-3376

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY VE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state laws to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect on April 14, 2003 and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice will be effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make a new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND HEALTH INFORMATION OF HEALTH INFORMATION

We use and disclose information about y9ou for treatment, payment, and healthcare operations; for example:

Treatment-We may use and disclose your health information to a physician or the healthcare provider providing treatment to you.

Payment-We may use and disclose your health information to obtain payment for services we provide for you.

Healthcare Operations-We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence of qualifications of healthcare professionals, evaluating practitioner and provider performances, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization-In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in the Notice.

To Your Family and Friends-We must disclose your health information to you, described in the Patient Rights of this Notice. We may disclose your health information to a family member, friend, or any other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree we may do so.

Persons involved in Care-We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services-We will not use your health information for marketing communications without your written authorization.

Required by Law-We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect-We may use or disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert serious threat to your health or safety to others. (continued)

NOTICE OF PRIVACY PRACTIES (continued)

National Security-We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counter-intelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders-We may use or disclose your health information to provide you with appointment reminders (such as voice mail messages, postcards, text, or letters).

Patient Rights

Access-You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photo copies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses, such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $1.00 for each page and $25.00 per hour of staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.
Disclosure Accounting-You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations, and certain activities for the last six (6) years, but not before April 14, 2003. If you request this accounting more than once in a twelve (12) month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
Restriction-You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).
Alternative Communications-You have the right to request that we communicate with you about health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location your request.
Amendment- You have the right to request that we amend yo9ur health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.
Electronic Notice-If you receive this Notice on our website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or have us communicate with you by alternative means or at alternative locations, you may complain to us by using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Service upon your request.

We Support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Office:	**Glynis Ablon M.D. F.A.A.D./Ablon Skin Institute**
Address:	**1600 Rosecrans Ave., Bldg 4B, Manhattan Beach, Ca. 90266**
Telephone:	**310-727-3376 / FAX 310-727-3377**

Ablon Skin Institute
Dermatology and Cosmetic Surgery
1600 Rosecrans Ave. 6A, #12
Manhattan Beach, CA. 90266
310-727-3376

REQUEST FOR LIMITATIONS AND RESTRICTIONS OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT PLEASE NOTE: THE PRACTICE IS NOT REQUIRED TO AGREE TO YOUR REQUEST. PLEASE SEE OUR NOTICE OF PRIVACY PRACTICES FOR MORE INORMATION REGARDING SUCH REQUESTS.

PATIENT NAME _____

PATIENT ADDRESS _____

DATE OF BIRTH _____

How would you like your PHI restricted?

_____

_____

	Y	N
Can we call you at home for appointment reminders?	____	____
Can we leave a message regarding your care on home voice mail or answering machine?	____	____
Can we call you at work regarding your care?	____	____
Can we send you mail to your home regarding the results of your biopsies or care? (Such mail will be marked confidential.)	____	____

Besides yourself, please list any other family members or nurses aides that you give us consent to discuss your care with:

_____ _____

_____ _____

_____ _____

Signature of Patient or Legal Guardian Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
**** YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT ****

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(SIGNATURE OF ACKNOWLEDGEMENT)

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