Jonna L. Schmidt, M.D., P.C. Privacy Program
If you have any questions about this notice, please contact
Angela Monahan, Office Manager

Your medical information is personal. We are committed to protecting your medical information. We create a record of the care and services you receive at this office. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this office whether made by your personal physician or one of the office's employees. This notice will tell you about the ways in which we may use and disclose your medical information. This notice will also tell your rights and certain obligations we have regarding the use and disclosure of your medical information.

This office is required by law to:

1. Make sure that medical information that identifies you is kept private.
2. Give you this notice of our legal duties and privacy practices with respect to medical information about you.
3. Follow the terms of the notice that is currently in effect.

This office may use and disclose your medical information for the following:

1. For Treatment
2. For Payment
3. For Health Care Operations
4. Appointment Reminders
5. Treatment Alternatives
6. As Required By Law
7. To Avert a Serious Threat to Health or Safety
8. Health Oversight Activities
9. Lawsuits and Disputes
10. Law Enforcement
11. Coroners and Medical Examiners
12. In the course of providing care, we will share patient information with other providers who are involved in your care, as appropriate. This data sharing may be written or electronic.

Your rights regarding your medical information are as follows:

1. Right to Inspect and Copy
2. Right To Amend
3. Right to an Accounting of Disclosures
4. Right to Request Restrictions

Telehealth

1. I hereby authorize Health Care Services to use the telehealth practice platform for telecommunication for evaluating, testing and diagnosing my medical condition.
2. I understand that technical difficulties may occur before or during the telehealth sessions and my appointment cannot be started or ended as intended.
3. I accept that the professionals can contact interactive sessions with video call; however, I am informed that the sessions can be conducted via regular voice communication if the technical requirements such as internet speed cannot be met.
4. I understand that my current insurance may not cover the additional fees of the telehealth practices and I may be responsible for any fee that my insurance company does not cover.
5. I agree that my medical records on telehealth can be kept for further evaluation, analysis and documentation, and in all of these, my information will be kept private.

We reserve the right to revise this notice. Any revised notice will be effective for medical information we already have about you as well as any information we receive in the future. Detailed descriptions of the above noted are available upon request. A full copy of our Privacy Standard is available upon request for your inspection.

I understand the above as it has been detailed for me.

Patient's Name____

____ ____________________

Signature of Patient/Parent/Guardian Date

Revised 9/16/2020