

**FLORIDA WESTCOAST SKIN AND CANCER CENTER**

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**NOTICE OF PRIVACY PRACTICES**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**Allowed uses and disclosures of your medical information:**

1.     The Florida Westcoast Skin and Cancer Center may use or disclose protected health information for the purposes of treatment, payment, or healthcare operations, for example: communications with health care providers and submission of health insurance claims.
2.     The Florida Westcoast Skin and Cancer Center may use or disclose protected health information for the following reasons:
  - A)     Uses and disclosures for public health activities;
  - B)     Reporting about victims of abuse, neglect or domestic violence;
  - C)     Disclosures for law enforcement purposes;
  - D)     Disclosures for judicial and administrative proceeding
  - E)     Disclosures to avert a serious threat to health or safety;

**Additional uses disclosures:**

1.     Florida Westcoast Skin and Cancer Center may contact the patient to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to the patient.

**You have the right to:**

1.     Request restrictions on certain uses and disclosures, however, we are not required to agree to any requested restriction.
2.     Receive confidential communications from us upon written request.
3.     Inspect and request copies of your medical information.
4.     Receive an accounting of any disclosures made, upon written request.
5.     Receive a paper copy of the notice upon request.

**We are responsible for:**

1.     Maintaining the privacy of your medical information.
2.     Providing this notice.
3.     Abiding by the terms of this notice.
4.     Providing written notice of any change to this notice.

**Complaints:**

You may complain to us or to the Health & Human Services secretary if you believe that your privacy has been violated. If you wish to file a complaint with us, please provide the office manager with a written notice of how you believe we violated your privacy. All notices received will be investigated and reviewed by a physician. We will respond within two weeks, and we will not retaliate for any allegations you make.

**Authorization:**

Upon your authorization, we may disclose your complete medical information, including pathology and billing information to a requesting entity, such as an attorney, another provider, or a relative. Unless otherwise specified we reserve the right to release as much information as we feel necessary pertaining to the request. You may revoke any authorization you make at any time, except to the extent that it was already relied on.

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**Patient signature**

**Date**