



**Houston Arrhythmia Associates, P. A.**  
**915 Gessner, Suite # 585 Houston, TX 77024**  
Sohail Jalal, M.D. Alexander Drtil M.D.

---

**PRIVATE POLICY**

In order to continue to provide you with the quality care in which you have become accustomed to in our office, as well as operate in an efficient manner, we will need to access your private health care information for the purpose of treatment, payment, and operations, (such as quality assurance). In using this information, this office will comply with all State and Federal Laws pertaining to your privacy rights; including the Privacy & Security protections provided to you by the Health Insurance Portability and Accountably Act (HIPAA).

We will need to disclose your private information under the following circumstances:

- **Sharing information for the purpose of treatment:** We will share information with all the members of your treatment team, both within this office and with other providers, (personal and institutional), in order to provide you with quality care and the educational/wellness programs specified in your insurance plan.
- **Sharing of information for the purpose of payment:** We will share all necessary information wit your insurer(s) payer(s), government entities (such as Medicare, Medicaid, ect.), and their representatives (including, but not limited to) benefit determination and utilization review as well as representative involved in the billing process (including, but not limited to) claims representatives and billing companies.
- **Sharing information for the purpose of operations:** We will share information necessary for the ongoing operations of this office, including (but not limited to) the credentialing process, peer review, accreditation, and compliance with all State and Federal Laws.

Your consent for the use and disclosure of information as described may be revoked in writing at any time. Please notify the office/ Privacy Officer if you ever decide to revoke your consent.

Your signature indicates your consent has been given freely. You understand that you may revoke this consent at any time, if that revocation is in writing, but any disclosures given in reliance on this prior consent will be permissible

\_\_\_\_\_  
Printed name

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date