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. PLEASE REVIEW IT CAREFULLY.

Understanding Your Health Record/Information
This notice describes the practices of (COMPANY NAME) and its staff (collectively, "**Practice**"), and that of any physician or provider with staff privileges with respect to your protected health information created while you are a patient at Practice. Practice, physicians with staff privileges and personnel authorized to have access to your medical chart are subject to this notice. In addition, Practice and physicians with staff privileges may share medical information with each other for treatment, payment or health care operations described in this notice.

We create a record of the care and services you receive at Practice. We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. This notice applies to all the records of your care at Practice.

This notice will tell you about the ways in which we may use and disclose medical information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of medical information.

Your Health Information Rights
Although your health record is the physical property of Practice, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information for treatment, payment and health care operations, and as to disclosures permitted to persons, including family members involved with your care and as provided by law. However, we are not required by law to agree to a requested restriction, unless the request relates to a restriction on disclosures to your health insurer regarding health care items or services for which you have paid out of pocket and in full;
- Obtain a paper copy of this notice of information practices;
- Inspect and request a copy of your health record as provided by law;
- Request that we amend your health record as provided by law. We will notify you if we are unable to grant your request to amend your health record;
- Obtain an accounting of disclosures of your health information as provided by law; and
- Request communication of your health information by alternative means or at alternative locations. We will accommodate reasonable requests.

You may exercise your rights set forth in this notice by providing a written request to (COMPANY NAME): (COMPANY ADDRESS).

Our Responsibilities
In addition to the responsibilities set forth above, we are also required to:

- Maintain the privacy of your health information;
- Subject to certain exceptions under the law, provide notice of any unauthorized acquisition, access, use or disclosure of your protected health information, to the extent it was not otherwise secured;
- Provide you with a notice as to our legal duties and privacy practices with respect to information we maintain about you;
- Abide by the terms of this notice; and
- Notify you if we are unable to agree to a requested restriction on certain uses and disclosures.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain, including information created or received before the change. Should our information practices change, we are not required to notify you, but we will have the revised notice available upon your request at Practice.

Uses and Disclosures of Medical Information That Do Not Require Your Authorization
The following categories describe different ways that we may use and disclose medical information without your authorization. We will explain what we mean for each category of uses or disclosures, but not every use or disclosure in a category will be listed. However, all the ways we are permitted to use and disclose information without your authorization should fall within one of the categories.

We will use your health information for treatment.

- **For example:** We may disclose medical information about you to doctors, nurses, technicians, medical students or other personnel who are involved in taking care of you. We may share medical information about you in order to coordinate different treatments, such as prescriptions, lab work and x-rays. We also may provide your physician or a subsequent health care provider with copies of various reports to assist in treating you once you are discharged from care at Practice.

We will use your health information for payment.

- **For example:** A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

We will use your health information for regular health care operations.

- **For example:** We may use the information in your health record to assess the care and outcome in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and services we provide.

We will use and disclose your health information as otherwise allowed by law. Examples of *those uses and disclosures follow:*

- **Business associates:** There are some services provided in our organization through

agreements with business associates. Examples include answering services and copy services. To protect your health information, however, we require business associates to appropriately safeguard your information.

- **Notification:** Unless you object, we may use or disclose information to notify or assist in notifying a family member, a personal representative or another person responsible for your care about your location and general condition.
- **Individuals involved in your care:** Unless you object, we may disclose to a family member, another relative, a close personal friend or another person you identify the health information that is directly relevant to that person's involvement in your health care or payment for your health care. If you are not able to agree or object to such disclosure, we may disclose the information as necessary if we determine it is in your best interest in our professional judgment.
- **Disaster relief:** We may use or disclose your health information to public or private disaster relief organizations to coordinate your care or to notify your family or friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to these disclosures when practical.
- **Research:** We may disclose information to researchers when their research has been approved by an institutional review board that has established protocols to protect the privacy of your health.
- **Communications regarding treatment alternatives and appointment reminders:** We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- **Food and Drug Administration (FDA):** We may disclose to the FDA health information relative to adverse events with respect to food, medications, devices, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs or replacement.
- **Worker's compensation:** We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.
- **Public health:** As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.
- **Abuse, neglect or domestic violence:** As required by law, we may disclose health information to a governmental representative authorized by law to receive reports of abuse, neglect or domestic violence.
- **Judicial, administrative and law enforcement purposes:** Consistent with applicable law, we may disclose health information about you for judicial, administrative and law enforcement purposes.
- **Health oversight activities:** We may disclose health information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections and licensure.
- **Threats to health or safety:** We may use or disclose health information as allowed by law if we believe in good faith that it is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, or for law enforcement authorities to identify or apprehend an individual involved in a crime.
- **Special government functions:** We may disclose health information to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by

law, or for protective services to the President of the United States or certain other government officials. If you are a member of the military, we may disclose health information to military authorities under some circumstances. If you are an inmate of a jail, prison or other correctional facility or in the custody of law enforcement personnel, we may disclose health information necessary to maintain your health and the health and safety of others.

- **Required or allowed by law:** We will disclose medical information about you when required or allowed to do so by federal, state or local law.
- **Electronic Health Information Exchange:** Practice uses a third party to maintain our electronic medical records (EMR). Practice stores electronic health information about you in the EMR. Practice monitors who can view your EMR.

When We Need Your Written Authorization

We will not use or disclose your health information without your written authorization, except as described in this notice. Additional circumstances that might require your additional written authorization are not common, but an example would be uses and disclosures for marketing purposes.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact Practice at [COMPANY PHONE NUMBER].

If you believe your privacy rights have been violated, you can send a complaint to the Director of Practice at [COMPANY ADDRESS], or to the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

This notice is effective on the following date: [DATE]

We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice at the office of each practice location where it can be seen.

Notice of Privacy Practices Acknowledgement

I, the undersigned, understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly;
- Obtain payment from third-party payers; and
- Conduct normal health care operations, such as quality assessments and physician certifications.

I acknowledge that I have been provided the *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

_____________ *(initials)* I acknowledge that my medical information/records will be released to Practice. I further acknowledge that my medical information/records will be released from Practice to my primary care provider, referring/consulting providers and my insurance company to process insurance claims.

I also allow release of my medical information to the following individuals (i.e. family, caregivers, etc.):

Name:	**Relationship:**
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

______________________________ ______________________________

Printed Patient Name **Date** **Signature of Patient**

______________________________ ______________________________

Practice Representative Name **Signature of Practice Representative/Witness**