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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. Please review it carefully.

WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU IN SEVERAL CIRCUMSTANCES

1. Treatment
I may use and disclose medical information about you to provide health care treatment to you. In other words, I may use and disclose medical information about you to provide, coordinate or manage your health care and related services. This may include communicating with other health care providers regarding your treatment and coordinating and managing your health care with others.

2. Payment
I may use and disclose medical information about you to obtain payment for healthcare services you received. This means that I may use medical information about you to arrange for payment (such as preparing bills and managing accounts). (See also section 5.2 under your rights with regards to medical information about you.)

3. Persons Involved in Your Care
I may disclose medical information about you to a relative, close personal friend or any other person you identify if that person is involved in your care and the information is relevant to your care. If the patient is a minor, I may disclose medical information about the minor to a parent, guardian or other person responsible for the minor except in limited circumstances. I may also use or disclose medical information about you to a relative, another person involved in your care if we need to notify someone about your location or condition.

You may ask me at any time not to disclose medical information about you to persons involved in your care. We will agree to your request and not disclose the information except in certain limited circumstances (such as emergencies) or if the patient is a minor. If the patient is a minor, we may or may not be able to agree to your request.

4. Healthcare Operations
We may use and disclose medical information about you in performing a variety of business activities that we call "healthcare operations."

- Cooperating with outside organizations that evaluate, certify or license healthcare providers, staff or facilities.
- Planning for our future operations.

- Resolving grievances within our organization.
- When control of our organization significantly changes
- When working with others (such as attorneys or accountants) who assist us.

5. Required by Law
I will use and disclose medical information about you whenever we are required by law to do so. Many state and federal laws require me to use and disclose medical information. Example: State law requires me to report gunshot wounds to the police and to report known or suspected child abuse or neglect to the Department of Social Services.

6. National Priority Uses and Disclosures
When permitted by law, I may use or disclose medical information about you without your permission for various activities that are recognized as "national priorities." We will only disclose medical information about you in the following circumstances when we are required to do so by law. Examples: Threats to health or safety; Public health activities; Abuse, neglect or domestic violence; Health oversight activities; Court proceedings; Law enforcement; Coroners, medical examiners, or funeral directors; Workers' compensation; Research; Certain government functions.

Authorizations
Other than the uses and disclosures described above (#1-6), I will not use or disclose medical information about you without the "authorization" – or signed permission – of you or your personal representative. In some instances, I may wish to use or disclose medical information about you and I may contact you to ask you to sign an authorization form. In other instances, you may contact me to ask me to disclose medical information and I will ask you to sign an authorization form.

If you sign a written authorization allowing me to disclose medical information about you, you may later revoke (or cancel) your authorization in writing. (If you would like to revoke your authorization, you may write me a letter revoking your authorization or fill out an Authorization Revocation Form. If you revoke your authorization, I will follow your instructions except to the extent that I have already relied upon your authorization and taken some action.

YOU HAVE RIGHTS WITH RESPECT TO MEDICAL INFORMATION ABOUT YOU

1. Right to a Copy of This Notice
You have a right to have a paper copy of this Notice of Privacy Practices at any time.

2. Right of Access to Inspect and Copy
You have the right to inspect (which means see or review) and receive a copy of medical information about you that I maintain in certain groups of records. If I maintain your medical records in an Electronic Health Record (EHR) system, you may obtain an electronic copy of your medical records. You may also instruct me in writing to send an electronic copy of your medical records to a third party. If you would like to inspect or receive a copy of medical information about you, you must provide me with a request in writing. I may be able to provide you with a summary or explanation of the information.

We may deny your request in certain instances. If we deny your request, we will explain our reason for doing so in writing. We will also inform you in writing if you have the right to have our decision reviewed by another person.

If you would like a copy of the medical information about you, we will charge you a fee to cover the costs of the copy. Our fees for electronic copies of your medical records will be limited to the direct labor costs associated with fulfilling your request.

3. Right to Have Medical Information Amended
You have the right to have us amend (which means correct or supplement) medical information about you that we maintain in certain groups of records. If you believe that we have information that is either

inaccurate or incomplete, we may amend the information to indicate the problem and notify others who have copies of the inaccurate or incomplete information. You must provide us with a request in writing and explain why you would like us to amend the information.

I may deny your amendment request in certain circumstances. If I deny your request, I will explain our reason for doing so in writing. You will have the opportunity to send me a statement explaining why you disagree with my decision to deny your amendment request and I will share your statement whenever I disclose the information in the future.

4. Right to an Accounting of Disclosures We Have Made
You have the right to receive an accounting (which means a detailed listing) of disclosures that I have made for the previous six (6) years. The accounting will not include several types of disclosures, including disclosures for treatment, payment or health care operations. If we maintain your medical records in an Electronic Health Record (EHR) system, you may request that we include disclosures for treatment, payment or health care operations. The accounting will also not include disclosures made prior to April 14, 2003.

If you request an accounting more than once every twelve (12) months, I may charge you a fee to cover the costs of preparing the accounting.

5. Right to Request Restrictions on Uses and Disclosures
You have the right to request that I limit the use and disclosure of medical information about you for treatment, payment and health care operations. Under federal law, I must agree to your request and comply with your requested restriction(s) if:

> The medical information pertains solely to a health care item or service for which the health care provided involved has been paid out-of-pocket in full.

Once I agree to your request, I must follow your restrictions (except if the information is necessary for emergency treatment). You may cancel the restrictions at any time. In addition, I may cancel a restriction at any time as long as I notify you of the cancellation and continue to apply the restriction to information collected before the cancellation.

6. Right to Request an Alternative Method of Contact
You have the right to request to be contacted at a different location or by a different method. For example, you may prefer to have all written information mailed to your work address rather than to your home address. I will agree to any reasonable request for alternative methods of contact. If you would like to request an alternative method of contact, you must provide us with a request in writing.

I am required by law to protect the privacy of medical information and provide Notice of my legal duties and privacy practices.

YOU MAY FILE A COMPLAINT ABOUT MY PRIVACY PRACTICES

If you believe your privacy rights have been violated, you may file a written complaint either with us or the federal government. We will not take any action against you or change our treatment of you in any way if you file a complaint. To file a written complaint with us, please bring your complaint directly to our Privacy Officer, or you may mail it to us at the address on the front of this Notice.

To file a written complaint with the federal government, please use the following contact information:
U.S. Department of Health and Human Services
Office for Civil Rights
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Toll-Free Phone: (800) 368-1019
TDD Toll-Free: (800) 537-7697

Website:
www.hhs.gov/ocr/privacy/hipaa/complaints/index.html
Email: OCRMail@hhs.gov

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