

Notice of Privacy Practices

We are committed to providing quality health care and respecting the privacy and confidentiality of your medical information. Our policies and procedures, outlined below, conform to state and federal laws. This notice describes how your medical information may be used and disclosed, and how you can get access to your information. Please review it carefully.

Effective date: April 14, 2003

Revised: April 2009

Information we need from you:

When you arrive at our practice for your appointment, we will ask you to sign in by writing your name on a designated form in our waiting room.

In order to contact you, we need current contact information. Please complete the registration form and provide your current telephone numbers (home, work, cell; please designate which one is your preferred contact) email, and home address.

We may need to contact you by telephone to discuss your appointments, test results, treatment, referrals, account balance, or simply to return your phone call. We would first attempt to call you at the number you designate as your preferred number. However, if you are not available, we would call you at the other phone numbers you have provided. We may leave a message for you to call the office. We may also leave information to remind you of an upcoming appointment.

We may mail correspondence to your home. Such correspondence may regard test results, appointments, and/or medical or non-medical information you have requested. In the event you do not pay all of your charges at the time of your visit, we will mail a statement to your home.

In order to honor your request to release or send medical records to third parties, you will be required to sign a medical release form, which will be provided by this office.

What we do with your information:

So that we may provide you or your child with appropriate medical care, perform general practice functions, and/or obtain payment, we will (at our discretion) provide information regarding the treatment received in this practice, the charges involved, and related information to other healthcare entities, such as:

- physicians
- nonphysician providers (e.g. physical therapist, nutritional counselors) who work outside of this practice
- medical facilities (e.g. hospitals, nursing homes)

- laboratories (for the purpose of performing medical tests)
- other healthcare providers (e.g. pharmacies, durable medical equipment suppliers, ambulance services, and electronic prescription services)
- school nurses
- insurance companies, in order to obtain payment, review medical necessity, or provide case management
- state or federal agencies that require the submission of specific health-related information

This information may be transmitted or shared electronically via the US Postal Service, fax, internet, voice mail, and/or personal communication. In addition, these persons, entities, sites, and locations may share medical information with each other for the treatment, payment, or healthcare operations purposes as described in this notice.

You and your health records:

You have the right to request to receive communications from us on a confidential basis by using *alternative* means for receipt of information or by receiving the information at *alternative* locations. For example, you can ask that we only contact you at work or by mail, or at another mailing address, besides your home address. We must accommodate your request, if it is reasonable. You are not required to provide us with an explanation as to the reason for your request. If you would like to receive copies of medical information after your treatment, you will need to specify the method and location at which the information should be sent to you.

You have the right to inspect and copy your protected health information (PHI). You may inspect and/or obtain a copy of your PHI, which is contained in a designated record set, for as long as we are required by law to maintain it. A "designated record set" contains medical and billing records and any other records that your physician and the practice use for making decisions about your care.

You must submit your request in writing to the practice manager in order to inspect and/or obtain a copy of your PHI. Our practice charges a fee for the cost of copying, mailing, labor, and supplies associated with your request. In certain rare circumstances, our practice may deny your request. However, you may request a review of our denial. In this case, a licensed healthcare professional chosen by us will review your request and the denial.

You have the right to request a restriction of the use of your PHI. You may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care, or for the notification purposes described above. Your request must state the specific restriction requested and to whom you want the restriction to apply.

If your physician believes it is in your best interest to use and disclose your PHI, it will not be restricted. If your physician agrees with the requested restriction, then we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any desired restriction with your physician. You may request a restriction at any time by providing a written request to the practice.

Your physician is not required to agree to your restriction; however, federal legislation obligates your physician to agree to your requested restriction if the disclosure is to a health plan for payment or health care operations purposes and the PHI relates to a health care item or service for which the health care provider has been paid out of pocket in full.

You have the right to request your physician amend your PHI, which resides in a designated record set, for as long as we are required by law to maintain this information. In certain cases, for example, if we think the information is correct, or was not created by our practice, we may deny your amendment request. In that case, you have the right to file a statement of disagreement with us, and we may prepare a rebuttal to your statement. You will receive a copy of any such rebuttal. Please contact our practice manager if you have questions about amending your PHI. To file an amendment, your request must be in writing and submitted to the practice manager.

You have the right to request an “accounting of disclosures.” This is a list of disclosures of your medical information that was not specifically authorized by you in advance, in accordance with state and federal regulations. To request this list of accounting of disclosures, you must submit your request in writing to the practice manager. Your request must state a time period that may not include dates before April 14, 2003. The first list you request within a 12 month period will be free. For additional lists, we may charge you for the administrative cost of providing them.

Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who receive one medication to those who received another for the same condition. All research projects, however, are subject to a specific approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with the patient’s need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process. We may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs.

Other uses and disclosures of medical information not covered by this notice or laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to reverse any disclosures we have already made with

your permission and that we are required to retain our records of the care that we provided to you.

If you believe your privacy rights have been violated, or have any questions or concerns with the policies and/or procedures noted above, please contact the practice manager to discuss them. We trust that you are comfortable with our efforts to maintain confidentiality of the information related to you or your child's medical care.

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our waiting room.