

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.

This notice takes effect on _____ and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our office. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We, also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the notice that is now in effect.

We have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that law permits the changes.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to privacy Practices:

1. Before we can make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose information. We will not use or disclose your medical information for any purpose other than those that are listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by putting it in writing to us.

FOR TREATMENT: We may use medical information about to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or others who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment and health care operations, we may use and disclose medical information for the following purposes.

Facility Directory: Unless you notify us that you object, the following medical information about you will be placed in our facilities directories: your name; your location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy, except for your religious affiliation, or to others who contact us and ask for information about you by name. PLEASE READ: SOME OF THE NOTES ABOVE AND BELOW MAY NOT APPLY TO THIS SPECIFIC FACILITY, HOWEVER IS STILL NOTED FOR YOUR INTEREST AND PROTECTION.

Notification: Medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency and if you are not available to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgement to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for/about you.

Disaster Relief: Medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fundraising: We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care in any fundraising materials; we will provide you a description of how you may choose to not receive future fundraising communications.

Research in Limited Circumstances: Medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Fractions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans. For national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and the other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an intimate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the

Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products or to conduct activities required by the FDA. We may also, when law authorizes us to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contacting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence: We may disclose information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence and other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health and safety or the health and safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being a part of a crime or has escaped legal custody.

Worker's Compensation: We may disclose health information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose health information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, criminal investigations or proceedings, inspections, licensure or disciplinary actions or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as reporting certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of law enforcement officials, reporting death, crimes on our premises and crimes in emergencies.

QUESTIONS AND COMPLAINTS

CONTACT US OF ANY QUESTIONS, COMPLAINTS OR IF YOU FEEL THAT YOUR RIGHTS HAVE BEEN VIOLATED. WRITTEN COMPLAINTS MAY BE SUBMITTED TO DEPT. OF HEALTH AND HUMAN SERVICES. WE WILL NOT RETALIATE IN ANY WAY IF YOU CHOOSE TO COMPLAIN AND MAY BE ABLE TO PROVIDE YOU WITH THE ADDRESS TO FILE YOUR COMPLAINT.

PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices. I have been provided the opportunity to review it in full and I am in understanding of it.

Name: _____

DOB: _____ **SS#:** _____

Signature: _____

Date: _____

COMPLAINT

1. To The Person

You have the right to file a complaint with us about our privacy practices or our compliance with our Notice of Privacy Practices, our privacy policies and procedures, or federal or state privacy rules or laws. We will investigate your complaint and give you our written answer. We will not require you to give up any right that you may have under federal or states privacy or any other law to file your complaint, and filing your complaint will not cause us to treat you badly. To use this right, please complete, sign and date the form below then submit it to our facility. If you have any questions, or you need more information to help complete this please contact our office. You may also submit a complaint to the U.S. Dept. of Health and Human Services. For information about how to do that, please contact us.

2. Section A: Person filing a complaint

Your Name: _____ SS#: _____

Date of Complaint filed: _____ DOB: _____

Your (reachable) Phone Number: _____ fax: _____

Your Current Address: _____

Email (if applicable): _____

Your patient Account Number (if known): _____

2. Section B: Person's Complaint

a. Please give a short, plain statement of your complaint:

b. Please give a short, plain statement of how you would like your complaint handled/solved:

4. Person's Signature

I certify that the statements made in this complaint are true and correct to the best of my information and belief. I understand that I have a right to have a copy of this complaint if needed.

Signature _____ Date _____

If a representative for the person who is launching the complaint files this complaint, complete the following:

Name _____ Date _____ Relation _____