

## **Notice of Privacy Practices for Protected Health Information**

### **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!**

With your consent, the practice is permitted by federal laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

#### **Example of uses of your health information for treatment purposes:**

A clinician obtains treatment information about you and records it in a health record. During the course of your treatment, the provider determines a need to consult with another specialist in the area. The provider will share the information with such specialist and obtain input.

#### **Example of use of your health information for payment purposes:**

We submit a request for payment to your health insurance company. The health insurance company requests information from us regarding medical care given. We will provide information to them about you and the care given.

#### **Example of use of your health information for Health Care Operations:**

We obtain services from our insurers or business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines developments, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates to obtain these services.

### **Your Health Information Rights**

The health record we maintain and billing records are the physical property of the practice. The information in it, however, belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted;
- Request that you be allowed to inspect and copy your health record and billing record- you may exercise this right by delivering the request in writing to our office;
- Appeal a denial of access to your protected health information except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office;
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your health information;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request. Or disclosure made to family members or friends in the course of providing care;
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office; and;
- Revoke authorization that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact our administrator, in person or in writing, during normal business hours. She will provide you with assistance on the steps to take to exercise your rights.

## **Our Responsibilities**

The practice is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice of our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a request; and
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

## **To Request Information or File a Complaint**

If you have questions, would like additional information, or want to report a problem regarding handling of your information, you may contact our office administrator.

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to our office administrator. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services whose street address and e-mail address is **200 Independence Ave. S.W. Washington, D.C., 20201, phone # 1-877-696-6775, <http://HHS.gov>**

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the practice.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary.

## **Other Disclosure and Uses**

### *Notification*

Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

### *Communication with Family*

Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

### *Food and Drug Administration (FDA)*

We may disclose to the FDA your protected health information relating to adverse events with respect to products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

### *Public Health*

As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

### *Abuse and Neglect*

We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

### *Law Enforcement*

We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

### *Health Oversight*

Federal law allows us to release your protected health information to appropriate health oversight agencies or health oversight activities.

### *Judicial/Administrative Proceedings*

We may disclose your protected health information in the course of any judicial or administrative proceedings as allowed or required by law, with your consent, or as directed by a proper court order.

Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke the authorization as previously provided.



**Notice of Privacy Practices Receipt**

Our notice of Privacy Practices (NPP) provides information on how our practice may use and/or disclose protected health information about you for treatment, payment, and health care operations. A copy of our NPP can be found on the GISD’s website under Staff/Departments& Programs/ Employee Clinic and at the front desk of the clinic.

I acknowledge I have received a copy of GISD Employee Clinic’s Notice of Privacy Practices.

Patient’s Name: \_\_\_\_\_  
(PRINT)

Patient’s Signature: \_\_\_\_\_  
(SIGNATURE)

Today’s Date: \_\_\_\_\_

Patient’s Date of Birth: \_\_\_\_\_

**If signed by Personal Representative: (Parent/Legal Guardian)**

Name of Representative: \_\_\_\_\_  
(PRINT)

Signature of Personal Representative: \_\_\_\_\_  
(SIGNATURE)

Driver’s License Number: \_\_\_\_\_

Today’s Date: \_\_\_\_\_

**\*\*DO NOT SIGN OR FILL OUT BELOW DOTTED LINE\*\***

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**For Practice Use Only:**

Patient’s Chart Number: \_\_\_\_\_

Signature of Employee: \_\_\_\_\_