

NOTICE OF PRIVACY PRACTICE

This Notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions, please contact any staff member here at the office.

Current federal healthcare law, called the **Health Insurance Portability and Accountability Act (HIPPA) Rule**, provides specific requirements aimed at protecting your privacy. This practice values the importance of trust and privacy involved in the physician-patient relationship and is committed to complying with these and all other regulations pertaining to your privacy. We have provided this general information about the Privacy Rule to help you better understand your privacy rights and our role in protecting those rights.

The Privacy Rule is a federal law requiring doctors and others involved in providing your **What is the Privacy Rule?** Healthcare to develop procedures regarding the use and release of your health information. It requires that our privacy practices, called *Notice of Privacy Practices*, be shared with you.

Who will follow this notice?

The practice of John B. Harris, MD provides healthcare to our patients and clients in partnership with physicians and other professional organizations. The information privacy practices in this notice will be followed by:

- Any health care professional who treats you here at this office/clinic.
- All full, part time, or contractual employees and volunteers, including students affiliating with this office/clinic.
- Any business associate or partner of John B. Harris, MD with whom we share health information.

Our pledge to you:

We value you as a client and appreciate the opportunity to serve you. We are committed to protecting health information about you. We create a record of the care and services you receive to provide quality care and to comply with legal requirements. This notice applies to all the records of your care that we maintain, whether created by our staff or your personal physician. By law, we are required to:

- Keep health information about you private.
- Give you this notice of our legal duties and privacy practices with respect to health information about you.
- Follow the terms of the notice that is currently in effect.

Changes to this notice:

We may change our policies at any time. Changes will apply to health information we already hold and to the future information after the change occurs. Before we make significant change to our policies, we will alter our notice and post the new notice for public view. You can receive a copy of the notice at any time. You will be offered a copy of our current notice each time you register at our facility for treatment. You will also be asked to acknowledge in writing your receipt of this notice

PHI - Protected Health Information

This includes any individually identifiable information about your past, present or future physical **How we may use and disclose your personal health information:**

or mental health or information related to the provision or payment of healthcare. Your personal information including social security number, birth date, and address are also protected.

- We may use and disclose health information about you for any purpose regarding your **treatment**, to obtain **payment for treatment** (such as comparing practice patterns to improve treatment methods.)
- We may use and disclose health information about you without your prior authorization for several other reasons, subject to certain requirements: for **public health purposes, abuse or neglect reporting, health oversight audits or inspections, research studies, worker's compensation purposes, and emergencies**. We also disclose health information **when required by law** (such as in response to valid judicial or administrative orders.)
- We also may contact you for appointment reminders, or to tell you about or recommend **possible treatment options, alternative, health related benefits, or durable medical goods** that may be of interest to you.
- We may disclose health information about you to a **friend or family member who is involved with your medical care**. If you have designated them to receive information.

Other uses of health information:

We will ask for your written authorization before using or disclosing health information about you in any other situation not covered by this notice. If you choose to authorize use of disclosures, you can later revoke that authorization by notifying us in writing of your decision.

How does HIPAA help protect my privacy?

- It gives you more control over your health information.
- It sets boundaries on the use and release of health records.
- It establishes safeguards to protect the privacy of health information.
- It holds violators accountable.
- It enables you to find out how your information may be used and what releases of information have been made.
- It limits release of information to the minimum needed to accomplish the purpose for the release.
- It gives you the right to examine and obtain a copy of your health records and request that corrections or amendments be made.

Your rights regarding personal health information:

- In most cases you have the right to look at or get a copy of health information that we use to make decisions about your care, after submitting a written request.
- We may charge a fee for the cost of copying, mailing, or related supplies. If we deny your request to review or obtain a copy of your health record, you may submit a written request for a review of that decision.
- If you think that information in your record is incomplete or incorrect, you have the right to request that we correct the records by submitting a written request that we amend them. We would deny the request in cases when the information was not created by us, not part of the information maintained by us, or if we determine that the record was accurate. You may appeal in writing a decision not to amend your record.
- **You have the right to a listing of those instances where we have disclosed medical information about you,** other than for treatment, payment, or health care operations, or where you specifically authorized the disclosure. You must submit a written request stating the time period desired for the accounting, which must be less than a six-month period and starting after April 14, 2003. The first disclosure list in a 12-month period is free. We will inform you before you incur charges for a subsequent list.
- **You have a right to a paper copy of this notice.**
- **You have the right to request that medical information about you be communicated to you in a confidential manner,** such as sending mail to an address other than your home, by notifying us in writing.

You may request in writing that we not use or disclose your health information for treatment, payment, or health care operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency.

We are not legally required to accept your request, but will consider it and inform you of our decision.

All written requests or appeals should be submitted to our Privacy Office listed at the end of this notice.

Complaints

- If you are concerned that your privacy rights may have been violated, or you disagree with a decision we made about access to your records, you may contact the Privacy Officer who is the Practice Administrator.
- Finally, you may send a written complaint, request a copy of the HIPAA Privacy rule or additional information about the rule at:

U. S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201
202-619-0257 or 877-696-6775
www.hhs.gov/ocr/hipaa

- Under no circumstances will you be retaliated against or penalized in any way.

_____ **Patient's Initials**

Patient Consent to the Use and Disclosure of Health Information For Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, John B. Harris, M.D. originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment;
- A means of communication among the many health professionals who contribute to my care;
- A source of information for applying my diagnosis and surgical information to my bill;
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent;
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment; payment, or health care operations.

I understand that John B. Harris, M.D. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that John B. Harris, M.D. reserves the right to change the notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should John B. Harris, M.D. changes the notice, the office will send a copy of any revised notice to the address I've provided (whether U.S. mail or if I agree, e-mail).

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept/decline the terms of this consent

Patient Signature (authorized representative for patient)

Date

FOR OFFICIAL USE ONLY

- () consent received by _____ on _____
- () Consent refused by patient, and treatment refused as permitted
- () Consent added to the patients medical record on _____