

# M.A PRIMARY & URGENT CARE CLINIC

## NOTICE OF PRIVACY PRACTICES

THE NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

In this notice we , describe the ways that we may use and disclose health information about our patients. The HIPAA Privacy Rule requires that we protect the privacy of health information that identifies a patient, or where there is a reasonable basis to believe the information can be used to identify a patient. This information is called “ Protected Health Information” or PHI. We are required by law to:

- Maintain the privacy of PHI about you;
- Give you this notice of our legal duties and privacy practices with respect to PHI;
- Comply with the terms of our Notice of Privacy Practices that is currently in effect.

## USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose your health information about you for treatment, payment and healthcare operations. For example:

**TREAT:** We may use or disclose your health information to obtain payment for services we provide to you.

**PAYMENT:** We may use and disclose your health information to obtain payment for services we provide to you.

**HEALTHCARE OPERATIONS:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**YOUR AUTHORIZATION:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information of to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time . Your revocation will not affect any use of disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

**TO YOUR FAMILY AND FRIENDS:** We must disclose your health information to you, as described in the patient rights section of this notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**PERSONS INVOLVED IN CARE:** We may use of disclose health information to notify , or assist in the notification of ( including identifying or locating ) a family member, your personal representative or another person responsible for your care, of your location, your general condition , or death. If you are present , then prior to use or disclosure of your health information , we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person’s involvement in your healthcare. We will also use our professionals judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**MARKETING HEALTH-RELATED SERVICES:** We will not use your health information for marketing communications without your written authorization.

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**REQUIRED BY LAW:** We may use or disclose your health information when we are required to do so by law.

**ABUSE OR NEGLECT:** We may use or disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**CORONERS, MEDICAL EXAMINER, FUNERAL DIRECTOR:** We may use or disclose your health information to a coroner or medical examiner to identify a deceased person and determine the cause of death., in addition, we may disclose information to funeral directors as authorized by law.

**LAWSUITS AND OTHER LEGAL PROCEEDINGS:** We may use or disclose your health information in response to subpoenas, discovery request, or other required legal processes when efforts have been made to advise you of the request or to obtain an order protecting the information requested.

**NATIONAL SECURITY :** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities.. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

**WORKERS COMPENSATION:** We may use or disclose your health information as authorized by workers' compensation laws or other similar programs that provide benefits for work related injuries or illness.

**APPOINTMENT REMINDERS:** We may use or disclose your health information to provide you with appointment reminders ( such as voicemail messages, postcards, or letters ).

### **YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU**

Under Federal law, you have the following rights regarding health information about you:

**ACCESS:** You have the right to look at or get copies of your health information, with limited exceptions.

**DISCLOSURE ACCOUNTING:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purpose, other than treatment , payment, healthcare operations and certain other activities, for the last six years, but not before April 14,2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable . Cost-based fee for responding to these additional requests.

**RIGHT TO REQUEST RESTRICTIONS:** You have the right to request that we place additional restrictions on use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement ( except in a emergency ).

**ALTERNATIVE COMMUNICATION:** You have the right to request that we communicate with you about your health information by alternative means or alternative locations. ( You must make your request in writing). Your request must specify the alternative means and location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**AMENDMENT:** You have the right to request that we amend your health information. ( Your request must be in writing , and it must explain why the information should be amended). We may deny your request under certain circumstances.

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**ELECTRONIC NOTICE:** If you receive this notice by electronic mail ( e-mail ), you are entitled to receive this notice in written form.

*We reserve the right to make changes to this notice and to make such changes effective for all PHI we may already have about you. If and when this notice is changed, we will post copy in our office in a prominent location. We will also provide you with a copy, when you request it form our Privacy Officer.*

\*May we contact you using more than one method? Home # \_\_\_\_\_

Work # \_\_\_\_\_

Cell# \_\_\_\_\_

e-mail address \_\_\_\_\_

\*\*I have an ADVACED DIRECTIVE    Yes \_\_\_\_\_    No \_\_\_\_\_

\*\*\*I give permission for the following individual (s) to speak with M.A PRIMARY regarding my:  
Treatment/Condition    Account Information    Scheduling Information

\_\_\_\_\_

\_\_\_\_\_  
(Signature of Patient or Responsible Party)

\_\_\_\_\_  
(Date)