

## HIPAA Notice of Privacy Practices

Effective Date: 7/1/2013

**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.**

If you have any questions about this notice, please contact Shannon Simmons at 443-812-0604.

### **MY OBLIGATIONS:**

I am required by law to:

- Maintain the privacy of protected health information
- Give you this notice of my legal duties and privacy practices regarding health information about you
- Follow the terms of notice, currently in effect

### **HOW I MAY USE AND DISCLOSE HEALTH INFORMATION:**

The following describes the ways I may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, I will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer (Shannon).

***For Treatment.*** I may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, I may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside my office, who are involved in your medical care and need the information to provide you with medical care.

***For Payment.*** I may use and disclose Health Information so that I or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, I may give your health plan information about you so that they will pay for your treatment.

***For Health Care Operations.*** I may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of my patients receive quality care and to operate and manage my office. I also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

**Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services.** I may use and disclose Health Information to contact you to remind you that you have an appointment with me. I also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

**Individuals Involved in Your Care or Payment for Your Care.** When appropriate, I may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. I also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

**Research.** Under certain circumstances, I may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before I use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, I may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

#### **SPECIAL SITUATIONS:**

I will disclose Health Information when required to do so by international, federal, state or local law.

I may use or disclose your protected health information in the following situations without your authorization. These situations include: ***As Required by Law. To Avert a Serious Threat to Health or Safety. Military and Veterans, Workers' Compensation, Public Health Risks, Communicable Diseases, Abuse or Neglect, Food and Drug Administration requirements, Criminal Activity, Organ Donation Research, Health Oversight Activities. Data Breach Notification Purposes. Lawsuits and Disputes, Law Enforcement, Coroners, Medical Examiners and Funeral Directors, National Security and Intelligence Activities. Protective Services for the President and Others, and Inmates or Individuals in Custody.***

Under law, I must make disclosures to you and when required by the secretary of the department of health and human services to investigate or determine my compliance with requirements of Section 164.500.

#### **USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT**

**Individuals Involved in Your Care or Payment for Your Care.** Unless you object, I may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care., If you are unable to agree or object to such a

disclosure, I may disclose such information as necessary if I determine that it is in your best interest based on my professional judgment.

***Disaster Relief.*** I may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. I will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

**YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES, with the opportunity for you to object unless required by law.**

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to me will be made only with your written authorization. If you do give me an authorization, you may revoke it at any time by submitting a written revocation to the Privacy Officer (Shannon Simmons) and I will no longer disclose Protected Health Information under the authorization. But disclosure that I made in reliance on your authorization before you revoked it will not be affected by the revocation.

**YOUR RIGHTS:**

You have the following rights regarding Health Information I have about you:

***Right to Inspect and Copy.*** You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, and treatment notes. To inspect and copy this Health Information, you must make your request, in writing, to me. I have up to 30 days to make your Protected Health Information available to you and I may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. I may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. I may deny your request in certain limited circumstances. If I do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and I will comply with the outcome of the review.

***Right to an Electronic Copy of Electronic Medical Records.*** If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. I will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. I may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

**Right to Get Notice of a Breach.** You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

**Right to Amend.** If you feel that Health Information I have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to me.

**Right to an Accounting of Disclosures.** You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to me.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the Health Information I use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information I disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to me. I am not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If I agree, I will comply with your request unless the information is needed to provide you with emergency treatment.

**Out-of-Pocket-Payments.** If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and I will honor that request.

**Right to Request Confidential Communications.** You have the right to request that I communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to me. Your request must specify how or where you wish to be contacted. I will accommodate reasonable requests.

**Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask me to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our web site, [www.integratedwellnesspt.com](http://www.integratedwellnesspt.com). To obtain a paper copy of this notice, please ask me.

**CHANGES TO THIS NOTICE:**

I reserve the right to change this notice and make the new notice apply to Health Information I already have as well as any information we receive in the future. I will post a copy of our current notice at my office and on my website. The notice will contain the effective date on the first page, in the top right-hand corner.

**COMPLAINTS:**

If you believe your privacy rights have been violated, you may file a complaint with me or with the Secretary of the Department of Health and Human Services. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

For more information on HIPAA privacy requirements, HIPAA electronic transactions and code sets regulations and the proposed HIPAA security rules, please visit ACOG's web site, [www.acog.org](http://www.acog.org), or call (202) 863-2584.