

## OUR PLEDGE REGARDING MEDICAL INFORMATION:

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of care and services you receive from our providers. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by our providers. This applies whether the care was provided in our office, in the hospital, in a nursing facility, over the phone or in any other manner.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your right and certain obligations we have regarding the use and disclosure of medical information. We are required to abide by the terms of this Notice of Privacy Practices, but reserve the right to change the Notice at any time. Any change in the terms of this Notice will be effective for all Protected Health Information (PHI) that we are maintaining at that time. If a change is made to this Notice, a copy of the revised Notice will be provided to all covered individuals.

The Law requires us to:

- Make sure that medical information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice that are currently in effect.

## HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe different ways that we use and disclose medical information without your consent or authorization. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

**For Treatment.** We may use medical information about you to provide and coordinate your health care by a doctor, hospital or other health care provider. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you.

**For Payment.** We may use and disclose medical information about you so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company or a third party.

**For Health Care Operations.** We may use and disclose medical information about you for health care operations. Health Care Operations refers to the basic functions necessary to operate a medical group. These uses and disclosures are necessary to make sure that all of our patients receive quality care.

**As Required by Law.** We will disclose medical information about you when required to do so by federal, state, or local law.

**Business Associates.** To a Business Associate as part of a contracted agreement to perform services for the medical group.

**Appointment Reminders and Call Backs.** We may use and disclose medical information to contact you as a reminder that you have an appointment. We may also use information to contact you following an exam or procedure so as to verify your condition.

**Treatment Alternatives.** We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

**Health-Related Benefits and Services.** We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

**To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

**Organ and Tissue Donation.** If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donor bank, as necessary to facilitate organ or tissue donation and transplantation.

**Military and Veterans.** If you are a member of the armed forces, we may release medical information about you as required by military command authorities.

**Workers' Compensation.** We may release medical information about you for workers' compensation or similar programs.

**Public Health Risks.** We may disclose medical information about you for public health activities. These activities may include: the prevention or control of disease, report births and deaths, report child abuse or neglect, to notify people of recalls, and to report reactions to medications.

**Health Oversight Activities.** We may disclose medical information to health oversight agencies for activities authorized by law. These activities are necessary for the

government to monitor the health care system, government programs, and compliance with civil rights laws.

**Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

**Law Enforcement.** We may release medical information if asked to do so by a law enforcement official in response to a court order, to identify or locate a suspect, witness or missing person, about the victim of a crime, about a death believed to be a result of criminal conduct, about criminal conduct at the hospital, and in emergency circumstances to report a crime.

**Coroners, Medical Examiners, and Funeral Directors.** We may release medical information to a coroner or medical examiner. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

**Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official.

We will, if required by law, release your PHI to the Secretary of the Department of Health and Human Services for enforcement of Health Insurance Portability and Accountability Act (HIPAA).

#### OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reason covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

#### YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU:

You have the following rights regarding medical information we maintain about you.

**Right to Inspect and Copy.** You have the right to inspect and receive a copy of medical information that may be used to make decisions about your care. To inspect and/or receive a copy of medical information that may be used to make decisions about you, you must submit your request in writing to Lakeside Community

Healthcare Medical Group. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

**Right to Amend.** If you feel that medical information we have about you 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 legally maintained. You should contact the Privacy Official at your medical office to discuss this process.

**Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment or healthcare operations. To obtain this list, you must submit your request in writing to the designated Privacy Official at your medical office. It must state a time period, which may not be longer than six years and may not include dates prior to April 14, 2003. We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. You must make your request in writing to the Privacy Official at your medical office.

**Right to Request Confidential Communications.** You have the right to request that we 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 at work or by mail. You must make your request in writing to the Privacy Official at your medical office.

**Right to a Paper Copy of this Notice.** You have a right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, ask the Privacy Official at your medical office.

#### COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Privacy Official at our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, please ask to speak directly to the Privacy Official at our office. **You will not be penalized for filing a complaint.**

EFFECTIVE DATE: April 14, 2003.

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physicians certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

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### OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date:

Initials:

Reason: