NOTICE OF PRIVACY PRACTICES

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.

During your treatment at_____, doctors, nurses, and other caregivers may gather information about
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your medical history and your current health. This notice explains how that information may be used and shared with others. It also explains your privacy rights regarding this kind of information. The terms of this notice apply to health information created or received by_____. We are required by law 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; follow the terms of the notice that is currently in effect; and notify you in the event there is a breach of any unsecured protected health information about you.

YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED FOR THE FOLLOWING PURPOSES

Treatment: We may use your information to provide, coordinate, and manage your care and treatment. For example, a _____ physician may share your medical information with another physician for a consultation or a referral.

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 another third party. For example, we may need to give your health plan information about treatment you received at _____ so your health plan will pay us or reimburse you for the treatment. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. We may disclose information about you for purposes of an independent review of a denial of a claim based on lack of medical necessity.

Health Care Operations: We may use and disclose medical information about you for _____ 's health care operations.

Health care operations are the uses and disclosures of information that are necessary to run _____ and to make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services, and to evaluate the performance of our staff and physicians in caring for you.

Appointment Reminders and Other Health Information: We may use your medical information to send you reminders about future appointments. We may also send you refill reminders or other communications about your current medications. However, if we receive any financial remuneration for making such refill or medication communications beyond our costs of making the communication, we must first obtain your written authorization to make such communications. We may contact you with information about new or alternative treatments or other health care services or for purposes of care coordination, unless we receive financial remuneration in exchange for making the communication; in that case, we will obtain your written authorization to make such communications. However, we are not required to obtain your written authorization for face-to-face communications.

Fundraising: _____ , one of its business associates or _____ 's foundation may use certain information about you (specifically, your name, address, age, gender, date of birth and other demographic information; dates you received health care from _____ ; department of service information; treating physician; outcome information and health insurance status) to let you know about opportunities to raise funds for _____ . You have the right to opt-out of receiving such fundraising communications.

Each fundraising communication you receive will include an opportunity to opt-out of future fundraising communications. Alternatively, you may notify _____ to opt-out of fundraising communications.

Facility Directory: We may include certain limited information about you in our directory while you are a patient. This information may include your name, location in the facility, and your religious affiliation if you provide this information to us. The directory information, except for your religious affiliation and condition, may be released to people who ask for you by name. This is so your family, friends and clergy can know your location. Your religious affiliation may be given to a member of the clergy, such as a priest or rabbi, even if they don't ask for you by name. If you would prefer that we not make these disclosures, please notify_____.

To People Assisting in Your Care. _____ will only disclose medical information to those taking care of you, helping you to pay your bills, or other close family members of friends if these people need to know this information to help you, and then only to the extent permitted by law. We may, for example, provide limited medical information to allow a family member to pick up a prescription for you. If you are able to make your own health care decisions, this practice will ask your permission before using your medical information for these purposes. If you are unable to make health care decisions, we will disclose relevant medical information to family members or other responsible people if we feel it is in your best interest to do so, including in an emergency situation.

Research: Federal law permits _____ to use and disclose medical information about you for research purposes, either with your specific, written authorization or when the study has been reviewed for privacy protection by an Institutional Review Board or Privacy Board before the research begins. In some cases, researchers may be permitted to use information in a limited way to determine whether the study or the potential participants are appropriate.

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

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. Any disclosure must be only to someone able to help prevent the threat.

To Business Associates: Some services are provided by or to _____ through contracts with business associates.

Examples include _____s attorneys, consultants, collection agencies, and accreditation organizations. We may disclose information about you to our business associate so that they can perform the job we have contracted with them to do. To protect the information that is disclosed, each business associate is required to sign an agreement to appropriately safeguard the information and not to redisclose the information unless specifically permitted by law.

YOUR MEDICAL INFORMATION MAY BE RELEASED IN THE FOLLOWING SPECIAL LIMITATIONS

Organ and Tissue Donation: We may release your medical information to organizations that handle organ procurement or organ, eye or tissue transplantation, or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation. The information that they may disclose is limited to the information necessary to make a transplant possible.

Military and Veterans: If you are a member of the armed forces, we will release medical information about you as requested by military command authorities if we are required to do so by law, or when we have your written consent. We may also release medical information about foreign military personnel to the appropriate foreign military authority as required by law or with written consent.

Workers' Compensation: We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health: We may disclose medical information to public health authorities about you for public health activities. These disclosures generally include the following:

- Preventing or controlling disease, injury or disability;
- Reporting births and deaths;
- Reporting child abuse or neglect, or abuse of a vulnerable adult;
- Reporting reactions to medications or problems with products;
- Notifying people of recalls of products they may be using;
- Notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; or
- Reporting to the FDA as permitted or required by law.

Health Oversight Activities: _____ may disclose medical information to a health oversight agency for health oversight activities that are authorized by law. These oversight activities include, for example, government audits, investigations, inspections, and licensure activities. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: We may disclose medical information about you in response to a valid court order or administrative order. We also may disclose your medical information in response to certain types of subpoenas, discovery requests or other lawful process. We may disclose information in the context of civil litigation where you have put your condition at issue in the litigation.

Law Enforcement: We may release medical information if asked to do so by a law enforcement official in response to a valid court order, grand jury subpoena, or warrant, or with your written consent. In addition, we are required to report certain types of wounds, such as gunshot wounds and some burns. In most cases, reports will include only the fact of injury, and any additional disclosures would require your consent or a court order.

We may also release information to law enforcement that is not a part of the health record (in other words, **non-medical** information) for the following reasons:

- To identify or locate a suspect, fugitive, material witness, or missing person;
- If you are the victim of a crime and, if, under certain limited circumstances, we are unable to obtain your agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at our facility; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners, and Funeral Directors: We will release medical information to a coroner or medical examiner in the case of certain types of death, and we must disclose health records upon the request of the coroner or medical examiner. This may be necessary, for example, to identify you or determine the cause of death. We may also release the fact of death and certain demographic information about you to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities: We will release medical information about you to authorized federal officials for intelligence, counter-intelligence, and other national security activities only as required by law or with your written consent.

Protective Services for the President and Others: We will disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or conduct special investigations only as required by law or with your written consent.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we will release medical information about you to the correctional institution or law enforcement official only as permitted by law.

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 your medical information that is used to make decisions about your care. Usually, this includes medical and billing records maintained by _____.

If you wish to inspect and copy medical information, you must submit your request in writing to_____. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request, to the extent permitted by state and federal law. If we maintain your health information electronically as part of a designated record set, you have the right to receive a copy of your health information in electronic format upon your request. You may also direct us to transmit your health information (whether in hard copy or electronic form) directly to an entity or person clearly and specifically designated by you in writing.

We may deny your request to inspect and copy your information in certain very limited circumstances. For example, we may deny access if your physician believes it will be harmful to your health or could cause a threat to others. In these cases, we may supply the information to a third party who may release the information to you. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by_____will review your request and the denial.The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Request Amendment: If you believe that medical information we have about you is incorrect or incomplete, you have the right to ask us to change the information. You have the right to request an amendment for as long as the information is kept by or for

_____.
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To request a change to your information, your request must be made in writing and submitted to _____.

In addition, you must provide a reason that supports your request.

_____ may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by _____, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for _____;
  ENTITY
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

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. This list will not include disclosures for treatment, payment, and health care operations; disclosures that you have authorized or that have been made to you; disclosures for facility directories; disclosures for national security or intelligence purposes; disclosures to correctional institutions or law enforcement with custody of you; disclosures that took place more than six years before the date of the request; and certain other disclosures.

To request this list of disclosures, you must submit your request in writing to_____. Your request must state a time period for which you would like the accounting. The accounting period may not go back further than six years from the date of the request. You may receive one free accounting in any 12-month period. We will charge you for additional requests.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you. If you pay out-of-pocket in full for an item or service, then you may request that we not disclose information pertaining solely to such item or service to your health plan for purposes of payment or health care operations. We are required to agree with such a request, unless you request a restriction on the information we disclose to a health maintenance organization ("HMO") and the law prohibits us from accepting payment from you above the cost-sharing amount for the item or service that is the subject of the requested restriction. ***However, we are not required to agree to any other request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment or you request that we remove the restriction.

To request restrictions, you must make your request in writing to _____. In your request, you must tell us
NAME
(1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply, for example, if you want to prohibit disclosures to your spouse.

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 only at work or only by mail.

To request confidential communications, you must make your request in writing to _____.

We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted, and we may require you to provide information about how payment will be handled.

Right to a Paper Copy of This Notice: You have the right to receive a paper copy of this notice. You may ask us to give you a copy of this notice any time.

CHANGES TO THIS NOTICE

The effective date of this notice is_____, and it has been updated effective September 23, 2013.
We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you, as well as any information we receive in the future. If the terms of this notice are changed,

_____ will provide you with a revised notice upon request, and we will post the revised notice in designated locations at _____.

Complaints or Questions: If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with _____, or to ask a question about this Notice, contact_____, _____. All complaints must be submitted in writing.
NAME (TITLE) PHONE NUMBER
You will not be penalized for filing a complaint.

Other Uses and Disclosures of Protected Health Information: We are required to obtain a written authorization from you for most uses and disclosures of psychotherapy notes, uses and disclosures of protected health information for marketing purposes and disclosures that constitute a sale of protected health information. Except as described in this notice, we will not use or disclose your protected health information without a specific written authorization from you. If you provide us with this written authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose medical information about you for the reasons covered by your written authorization, except to the extent we have already relied on your authorization. We are unable to take back any disclosures we have already made with your permission, and we are required to retain our records of the care that we provided to you.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE

Under HIPAA, you have certain rights regarding the use and disclosure of your protected health information. These rights are more fully described in _____'s Notice of Privacy Practices.

_____ is permitted to revise its Notice of Privacy Practices at any time. We will provide you with a copy of the revised Notice of Privacy Practices upon your request.

By signing below, you are acknowledging that you have received a copy of _____'s Notice of Privacy Practices.

Patient name: _____

Patient Representative:_____

If signed by Patient Representative, state authority to act on behalf of patient: _____

_____

Signature: _____ Date:_____, 20 _____

ENTITY USE ONLY

I, _____, attempted to obtain the patient's acknowledgement of receipt of the Notice of Privacy Practices, but was unable to do so.

Reason acknowledgement not obtained:_____

_____

Signature: _____ Date:_____, 20 _____

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ Birthdate _____

Signature _____

Date _____