

## **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**

A federal regulation, known as the "HIPAA Privacy Rule," requires that we provide a detailed notice in writing of our privacy practices. The HIPAA Privacy Rule requires us to address many specific things in this Notice. If you have any questions about this notice, please contact our office manager at 315-253-9749, 615, North Seward Avenue, Auburn, NY 13021

### **WHO WILL FOLLOW THIS NOTICE**

This notice describes information about privacy practices followed by our employees, staff and other office personnel. The practices described in this notice will also be followed by health care providers you consult with by telephone who provides "call coverage" for your health care provider.

### **YOUR HEALTH INFORMATION**

This notice applies to the information and records we have about your health, health status, and the health care and services you receive at this office. We are required to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

**We reserve the right to make changes to this notice and to make such changes effective for all protected health information we may already have about our patients. If and when this notice is changed, we will post a copy in our office in a prominent location. We will also provide you with a copy of the revised notice upon your request.**

### **HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU**

Generally, we may not use or disclose your Protected Health Information (PHI) without your consent. Further, once your consent has been obtained, we must use or disclose your PHI in accordance with the specific terms of that consent.

The following are circumstances under which we are permitted by law to use or disclose PHI

about you without your written, signed consent:

**Treatment:** We may use and disclose health information about you to provide, coordinate or manage your health care and related services. We may consult with other health care providers regarding your treatment and coordinate and manage your health care with others. For example, we may use and disclose health information when you need a prescription, lab work, an x-ray, or other health care services. In addition, we may use and disclose health information about you when referring you to another physician, we may disclose health information to your new physician regarding whether you are allergic to any medications.

We may also disclose health information about you for the treatment activities of another health care provider. For example, we may send a report about your care from us to a physician that we refer you to so that the other physician may treat you.

**Payment:** We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. 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 **limited** health information to consumer reporting agencies relating to collection of payments owed to us.

**For Health care Operations:** We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional service we should offer, how we can become more efficient, or whether certain new treatments are effective.

**Appointment Reminders:** We may contact you as a reminder that you have an appointment for treatment or medical care at the office.

**Treatment Alternatives:** We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

**Health-Related Products and Services:** We may tell you about health-related products or services that may be of interest to you.

Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-related products and services. If you advise us in writing (at the address listed at the top of this notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes.

You may revoke your Consent at any time by giving us written notice. Your revocation will be effective when we receive it, but it will not apply to any uses and disclosures that occurred

before that time.

If you do revoke your Consent, we will not be permitted to use or disclose information for purposes of treatment, payment or health care operations, and we may therefore choose to discontinue providing you with health care treatment services.

### **SPECIAL SITUATIONS**

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

**To Avert a Serious Threat to Health or Safety:** We may use and disclose health 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.

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

**Research:** We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address, or other information that reveals who you are, or will be involved in your care at the office.

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

**Military, Veterans, National Security and Intelligence:** If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

**Worker's Compensation:** We may release health information about you for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.

**Public Health Risks:** We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

**Health Oversight Activities:** We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights law.

**Lawsuits and Disputes:** If you are involved in a lawsuit or a dispute, we may disclose health 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 health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

**Coroners, Medical Examiners and Funeral Directors:** We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

**Information Not Personally Identifiable:** We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

**Family and Friends:** We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objections. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to or disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies, or x-rays.

**Business Associates:** We may disclose health information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

## **WHY DO I HAVE TO SIGN A CONSENT FORM?**

When you sign the Authorization for Release of Information, you are giving Women's Health Specialists permission to use and disclose (provide to others) Protected Health Information for

treatment, payment, and health care operations, as described above. This permission does not include psychotherapy notes (defined in next section), psychosocial information (defined in section below), alcoholism and drug abuse treatment records, and other privileged categories of information, all of which require a separate permission. You will need to sign a separate consent form to have Protected Health Information given out for any reason other than treatment, payment, or health care operations or as required or permitted by law.

### **WHAT ARE PSYCHOTHERAPY NOTES?**

PSYCHOTHERAPY notes are notes recorded (in any form) by a mental health professional for the purpose of studying a conversation that took place during a private counseling session. This session can be with a single person, a group, or a family. Conversation notes from a counseling session are separated from the rest of the patient's medical record. PSYCHOTHERAPY notes do not include: notes about which medicines you are taking or how those medicines affect you; the start and stop times of counseling sessions; the types of treatment you are given; how often treatments are given; the results of clinical tests; and any summary of the following items: diagnosis, functions state, the treatment plan, symptoms, expected outcome, and progress to date.

### **WHAT IS PSYCHOSOCIAL INFORMATION?**

Psychosocial information is information given to your social worker about your family's social history and counseling services you have received.

### **WHY DO I HAVE TO SIGN A SEPARATE PERMISSION FORM?**

To provide patient Protected Health Information to other people for any reason other than treatment, payment, and health care operations or as required or permitted by law, we must have a permission form known as an Authorization Form signed by the patient or the patient's parent or legal guardian. This form clearly explains how they wish the information to be used and disclosed. The following are some examples of the information that require separate permission before we can release it:

- Psychotherapy notes
- Marketing purposes
- Fundraising purposes
- Receiving information about alternative treatments

### **OTHER USES AND DISCLOSURES OF HEALTH INFORMATION**

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written Authorization. We must obtain your Authorization separate from any Consent we may have obtained from you. If you give us Authorization to use or disclose health 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 information about you for the reasons covered by your written Authorization, but we

cannot take back any uses or disclosures already made with your permission.

If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization (different than the Authorization and Consent mentioned above) from you. In order to disclose these types of records for purposes of treatment, payment or health care operations, we will have to have both your signed Consent and a special written Authorization that complies with the law governing HIV or substance abuse records.

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

You have the following rights regarding health information we maintain about you:

**Right to Inspect the Copy:** You have the right to request the opportunity to inspect and receive a copy of your health information, such as medical and billing records, that we may use to make decisions about your care. This does not include psychotherapy notes or information gathered or prepared for a civil, criminal, or administrative proceeding. To inspect and copy your health information, you must submit a written request to our Privacy Official. If you request a copy of health information about you, we may charge you a reasonable fee for the copying, postage, labor and supplies used in meeting your request. We may deny your request to inspect and copy your health information only in limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with outcome of the review.

**Right to Amend:** You have the right to request that we amend health information about you as long as such information is kept by or for our office. To make this type of request you must submit your request in writing to our Privacy Official with your reason for the request. We 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:

- a.) We did not create, unless the person or entity that created the information is no longer available to make the amendment.
- b.) Is not part of the health information that we keep.
- c.) You would not be permitted to inspect and copy.
- d.) 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 for purposes other than treatment, payment and health care operations. To obtain this list, you must submit your request in writing to our Privacy Official. It must state a time period, which may

not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (paper or electronic). 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 health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

**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.

To request restriction, you may complete and submit the Request for restriction on Use/Disclosure of Medical Information to our Privacy Official.

**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.

To request confidential communications, you may complete and submit the Request for Restriction on Use/Disclosure of Medical information and /or Confidential Communication to our Privacy Official. 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.

**Right to a Paper Copy of This Notice:** You have the 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 such a copy, contact our Privacy Official.

## **CHANGES TO THIS NOTICE**

We reserve the right to change this notice, and 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. We will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

## **COMPLAINTS**

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of Department of Health and Human Services. To file a complaint with our office, contact our Practice Administrator at 315-253-9749 or 615 North Seward Avenue, Auburn, New York 13021. You will not be penalized for filing a complaint.

