

## **HIPAA Notice of Privacy Practices Fulton Family Health Associates, P.C.**

2613 Fairway Drive, Suite C, P.O. Box 6098, Fulton, Missouri 65251, Phone: (573) 642-1990, Fax: (573) 642-1866

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read this notice carefully. If you want access to your records you need to make an appointment, to amend your record you need to submit the correction in writing.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. 'Protected health information' is information about you, including demographic information, that may identify you and relates to your past, present, or future physical or mental health or condition or any health care services provided to you.

**Uses and Disclosures of Your Medical Information:** Fulton Family Health Associates, P.C. uses your medical information to provide you with medical treatment and services, to receive payment for those services, and in daily health care operations.

**Treatment:** We will use and disclose your medical information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, this medical practice may provide information to a home health agency that is providing care to you.

**Payment:** Your medical information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as, such as making a determination of eligibility for insurance benefits or coverage of treatment and services; or reviewing services provided to you for medical necessity. An example of this would be obtaining approval for a hospital stay from your health plan that might require your health information be disclosed to the health plan in order to obtain approval.

**Healthcare Operations:** We may use or disclose, as needed, your medical information in order to support the business activities (everyday operations) of Fulton Family Health Associates, P.C.. These activities include, but are not limited to quality assessment activities, employee review activities, training of medical students, licensing, conducting or arranging of other business activities. For example, we may disclose your medical information to medical students that see patients in our office. We may also call you by name in the waiting room when your physician is ready to see you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health activities, communicable diseases, food and drug administration, to government entities regarding abuse and neglect, health oversight activities, judicial and administrative proceedings, law enforcement, criminal activity, coroner, medical examiners, organ donation, research, special government functions, workers' compensation, and required uses and disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164-500.

We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

**Other Permitted and Required Uses and Disclosures:** Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, in writing, at any time, except to the extent your physician has taken some action in reliance on that information.

**Your Rights:** Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

**You have the right to inspect and copy your protected health information:** This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A 'designated record set' contains medical and billing records and any other records that your physician and the practice use for making decisions about you.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this reviewed. Please contact us if you have questions about access to your medical record.

**You have the right to request a restriction of your protected health information:** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information or if law requires such disclosure, your protected health information will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by written request.

**You have the right to request to receive confidential communication from us by alternative means or at an alternative location.** You have the right to obtain a paper copy of this notice from us upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

**You may have the right to have your physician amend your protected health information:** If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information:** We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

**Complaints:** You are protected from retaliation for any and all complaints you make. If you believe that your privacy rights have been violated, you may contact our Privacy Coordinator at (573) 449-4936, Privacy Officer at (573) 642-1990, or the Secretary of Health and Human Services at (816) 426-7278.

**Effective Date:** This notice was published and becomes effective on April 14, 2003.

We are required to maintain the privacy of your medical information. We are also required to follow the terms of this Notice of Privacy Practices. The most current copy of the notice will be available to you at your next appointment following its implementation or by calling the office manager at (573) 642-1990 and requesting one be sent to you by mail. The most recent version of the notice will also be posted in the waiting area of this medical office.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practice:

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_