



Integrated Medical Services

HIPAA 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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out Treatment, Payment or Health Care Operations and for other purposes that are permitted by law. It also describes your rights to access and control your PHI. PHI is information about you, including demographic information, that may identify you and that relates to your past, present and future physical or mental health or condition and related health care services.

Uses and Disclosures of PHI: Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law. At no time will any information of any kind relating to any of our patients be discussed outside of this office unless permitted or required by law.

Treatment: We will use and disclose your PHI 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, we would disclose your PHI, as necessary, to a home health agency that provides care to you or to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose and treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain approval for hospital admission.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may also use or disclose your PHI as necessary to contact you to remind you of your appointment.

We are also permitted to use or disclose your PHI without your written authorization for certain purposes: As Required By Law, Public Health Activities (e.g. preventing the spread of disease), Health Oversight Activities, Abuse or Neglect, Food and Drug Administration Requirements, Legal Proceedings, Law Enforcement Purposes, Coroners, Funeral Directors and Organ Donation, Criminal Activity, Military Activity and National Security, Worker's Compensation, Inmates.

Under certain circumstances, we may also use and disclose information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information and balances the research needs with patients' need for privacy of their PHI. Before we use or disclose PHI for research, the project will have been approved through this research approval process. However, we may disclose your PHI to people preparing to conduct a research project, so long as the PHI they review is not removed from us. We may also use or disclose your PHI to contact you (or, under certain circumstances, to allow a research entity with whom we contract to contact you) about the possibility of enrolling in a research study.

If you do not want to be contacted about the possibility of enrolling in a research study (as described above), please initial here: _____

Other permitted and required uses and disclosures will be made with your authorization. You may revoke your authorization at any time in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

We may not receive direct or indirect remuneration in exchange for your PHI without your authorization except in limited circumstances permitted by law. We may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments or health-related benefits and services. We do not receive any compensation in connection with communications with you about any products or services, except we may communicate with you about prescription drugs or biologics and receive payment from the manufacturer that is reasonable in amount and compensates us for the costs we incurred in connection with that communication. Except for communications about drugs or biologics, we will obtain your authorization if we will receive direct or indirect payment for communicating with you.

We may enter into contract with entities known as Business Associates that provide services to or perform functions on our behalf. We may disclose PHI to Business Associates once they have agreed in writing to safeguard the PHI. For example, we may disclose your PHI to a Business Associate to administer claims. Business Associates are also required by law to protect PHI.

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.

Your Individual Rights: Following is a statement of your rights with respect to your PHI:

You have the right to inspect and copy your PHI. If we use or maintain an electronic health record for you, you may get that information in electronic format and ask us to send it to a person or organization that you identify. 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 PHI that is subject to law that prohibits access to PHI.

You have the right to request a restriction on the use or disclosure of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purpose of Treatment, Payment or Health Care Operations. You may also request that any part of your PHI 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 be in writing and state the specific restriction requested and to whom you want the restriction to apply. We will consider your request, but in most cases are not legally obligated to agree to those restrictions (e.g., if your physician

believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted, but you then have the right to use another Healthcare Provider). However, we will comply with any restriction request if the disclosure is to a health plan for purposes of payment or health care operations (not for treatment) and the PHI pertains solely to a health care item or service that has been paid for out-of-pocket and in full.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

You have the right to have your physician amend your PHI. If we deny your request for 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 PHI. Your request for an accounting must be submitted in writing. If we use or maintain an electronic health record for you, you may get a list of the disclosures we have made, if any, of your electronic health record for three years prior to the date of your request. For accountings that do not include disclosures made through an electronic health record, the request may not cover a time period longer than six years from the date of the request.

You have the right to be notified of a breach. You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of your unsecured PHI. Notice of any such breach will be made in accordance with federal requirements.

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.

This notice was published and becomes effective on/or before March 1, 2011. 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 by this notice. You can also request a copy of this notice at any time.

You may complain to us or to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our HIPPA Compliance Officer. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of PHI and to provide individuals with this notice of our legal duties and privacy practices with respect to PHI. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at (602)633-3838.

Signature below is acknowledgment that you have read and understand our Privacy Practices.

Patient Name: _____ DOB: _____

Signature: _____ Date: _____

Release of Information

I _____ hereby authorize IMS to release or discuss any and all information pertaining to myself or my medical records with the following people.

Name: _____ Relationship: _____ Phone Number _____

Name: _____ Relationship: _____ Phone Number _____

Name: _____ Relationship: _____ Phone Number _____

I authorize IMS to contact me at:

Home Phone _____ Work Phone _____

May we leave a message on machine? Yes No

Cell Phone _____ Alternate Phone _____

Patient Signature _____ **Date** _____

Witness: _____ Date _____