

# **HIPAA NOTICE OF PRIVACY PRACTICES AND ACKNOWLEDGEMENT**

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*This notice takes effect on April 14, 2003, and remains in effect until we replace it.*

**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 AND SIGN THE ACKNOWLEDGEMENT ON THE LAST PAGE.**

## **1. OUR COMMITMENT TO PROTECTING HEALTH INFORMATION ABOUT YOU**

The privacy of your medical information is important to us. We create a record of your medical history and the services you receive at our organization and/or under our direction so we can provide you with quality care and to comply with certain legal requirements. The HIPAA Privacy Rule requires that we protect the privacy of health information that identifies a patient, or where there is reasonable basis to believe the information can be used to identify a patient. This information is called "protected health information" or "PHI." This notice describes your rights and our obligations regarding the use and disclosure of your PHI.

**HIPAA Law Requires Us to:**

1. Maintain the privacy of your medical information (PHI);
2. Provide you with this Notice of Privacy Practices and obtain your signed acknowledgement of such disclosure;
3. Comply with the terms of this Notice that is currently in effect.

**We Have the Right to:**

1. Change our privacy practices and the terms of this Notice so long as we make the revised Notice available upon your request.
2. Make the changes in our privacy practices and the new terms of our notice effective for all PHI that we keep, including information previously created or received before the changes.

## **2. USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION**

Ways that we may use and disclose medical information for the *purposes* of treatment, payment, health care operations and other purposes: *(Not every example of use or disclosure is listed).*

### **FOR TREATMENT:**

We may use and disclose medical information about you to provide, coordinate or manage your health care. We may consult with other health care providers, including physicians, nurses, technicians, medical students, pharmacies or others who are involved in your care. For example, we may use and disclose PHI when you need a prescription, lab work, x-rays, therapy, or other health services to assist your other health care providers in treating you. In addition, we may use and disclose PHI about you when referring you to another health care provider (for example, allergies, medications or pertinent injuries or illnesses).

### **FOR PAYMENT:**

We may use and disclose PHI so that we can bill and collect payment for the treatment and services provided to you. We may share details with your health insurance carrier concerning the services you are wishing to receive or have received to determine your benefits. For example, we may ask for a referral or prior approval from your insurance carrier before we provide care or services. We may use and disclose PHI for billing, claims management, and collection activities. We may disclose limited PHI to consumer reporting agencies related to collection of payments owed to us.

### **FOR HEALTH CARE OPERATIONS:**

We may use and disclose PHI in performing general health care operations and activities that allow us to improve the quality of care we provide and to reduce health care costs. This might include quality improvement, general business activities, evaluating the performance of employees or other health care providers, training programs, cooperating with auditing agencies, and getting the accreditation, certificates, and licenses we need to serve you. We may contact you to remind you of appointments and to provide you with treatment results or treatment alternatives or other health-related benefits and services that may be of interest to you.

### **ADDITIONAL USES AND DISCLOSURES:**

**1. Notification to individuals involved in your care or payment for your care:** Per your consent, we may disclose PHI about you to your family member, close friend or any other person identified by you if that information is directly relevant to their involvement in your care or payment for your care. In case of emergency, or if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will use our professional judgment to make decisions in your best interest about allowing this person to pick up medicine, medical supplies, x-ray or medical information for you. We may also notify such persons of your location, condition or death.

**2. Disaster Relief:** We may use or disclose your PHI to authorized persons or agencies to assist in disaster relief efforts.

**3. Specialized Government Functions:** Subject to certain requirements, we may disclose PHI for military activity, national security and intelligence activities, protective services for the President and others, medical suitability determinations for the Department of State, correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

**4. Law Enforcement, Court Orders and Judicial and Administrative Proceedings:** We may disclose PHI in response to a court or administrative order, subpoena, discovery request, or to report a crime, emergency or death as a result of a crime, or other lawful process, under certain circumstances. We may share limited information with law enforcement officials to help identify or locate a suspect, fugitive, material witness, crime victim or missing person. We may share PHI of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

**5. Public Health Activities:** We may use or disclose PHI to public health authorities for activities related to the following: 1) To prevent, control or report disease, injury, disability, birth or death; 2) To report problems with products or devices regulated by the FDA; 3) To locate and notify persons of recalls of products they may be using; 4) To prevent a threat to the health or safety of a person or to the public.

**6. Abuse, Neglect, or Domestic Violence:** We may disclose PHI in certain cases to proper government authorities if we reasonably believe that a patient has been a victim of child or domestic violence, abuse or neglect.

**7. Health Oversight Activities:** We may disclose PHI to a health oversight agency for oversight activities including audits, investigations, inspections, licensure and disciplinary activities and other authorized activities.

**8. Worker's Compensation:** We may disclose PHI to comply with laws relating to worker's compensation programs.

**9. Research:** We may provide PHI for research purposes in limited circumstances where the research has been approved by a review board that has established protocols to ensure the privacy of medical information. We must obtain written authorization from you for disclosure of PHI in situations where the research project has not met the specified criteria.

**10. Funeral Director, Coroner, Medical Examiner, Organ Procurement:** We may share the PHI of a deceased person with a funeral director, coroner, medical examiner or an organ procurement organization as deemed necessary.

**11. Disclosures Required By HIPAA Privacy Rule:** We are required to disclose PHI to you as indicated below and to the Secretary of the United States Department of Health and Human Services when requested to review our compliance with the HIPAA Privacy Rule.

**Other uses and disclosures will be made only with your consent, authorization, or opportunity to object unless required by law. You may revoke this authorization at any time except to the extent that we have already taken an action based on this authorization.**

### **3. YOUR INDIVIDUAL RIGHTS REGARDING PROTECTED HEALTH INFORMATION**

#### **You Have a Right to:**

- Obtain copies of your medical and/or billing information except as restricted by law. Your request must be in writing and sent to the address at the end of this form. We will assess a fee for copying and mailing your record. All copy requests will be sent regular mail within 10 days of receipt of request and payment to the address designated on the request.
- Receive an accounting of disclosures we have made for purposes other than treatment, payment, health care operations and other specified purposes identified in this Notice. The period of time must be specified and must not be before this Notice was in effect. We may charge you our reasonable costs of providing this information.
- Request, in writing, that we place additional restrictions on our use or disclosure of your medical information, including 1) the information you want restricted, 2) how you want to restrict the information, and 3) to whom you want those restrictions to apply. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
- Request that we communicate with you about your medical information by a specific means (phone, fax, email) or to a specific address, which request must be reasonable and designated in writing.
- Request, in writing and with noted and legitimate reason, that we amend your medical information as created by our office. We may disagree or deny your request if we did not create the information you want changed or if you fail to give us your request in writing or fail to give us a legitimate reason for your request.
- Receive a paper copy of this notice upon request even if you have previously agreed to receive it electronically.

### **4. CONTACT INFORMATION FOR REQUESTS, QUESTIONS OR COMPLAINTS**

If you have any questions about this Notice, please contact:

**River City Plastic Surgery, P.C.**  
*HIPAA Compliance Officer*  
3241 West Truman Blvd, Suite 100  
Jefferson City, MO 65109  
(573) 635-9668

If you believe that your privacy rights have been violated, you may file a written complaint with our office noted above or with the Secretary of the US Department of Health and Human Services. We will not retaliate or take action against you for filing such a complaint.

**PLEASE SIGN THE ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES ON THE FOLLOWING PAGE. THE SIGNED ACKNOWLEDGEMENT WILL BE KEPT IN YOUR MEDICAL RECORD AS PROOF OF OUR DISCLOSURE TO YOU REGARDING OUR PRIVACY PRACTICES.**

**PARTY TO WHOM MY PERSONAL HEALTH INFORMATION MAY BE DISCLOSED:**

**Other than Myself, the following individuals may have full disclosure to my personal health information:**

(Please check one or more as applicable)

My Spouse

Either of my parents OR  My Mother

My Father

My Primary Care Physician, referring physician, chiropractor, therapist, psychologist and/or any physician I have previously or am currently seeing that would have or need information related to my care.

Other: Full Name \_\_\_\_\_ Phone # \_\_\_\_\_ Relationship \_\_\_\_\_

**Please note:** In case of emergency, or if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will use our professional judgment to make decisions in your best interest about allowing this person to pick up medicine, medical supplies, x-ray or medical information for you. We may also notify such persons of your location, condition or death.

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I have received the **HIPAA NOTICE OF PRIVACY PRACTICES** (2 pages) with an effective date of April 14,2003, and have been provided an opportunity to review it.

\_\_\_\_\_  
Printed Name of Patient or Legal Guardian

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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