HIPAA NOTICE OF PRIVACY PRACTICES

BARBARA E. HOWARD, M.D.
River City Plastic Surgery, P.C.
3241 W. Truman Blvd, Suite 100
Jefferson City, MO 65109

This notice takes effect on January 17, 2013, and remains in effect until we replace it.

THIS NOTICE DESCRIBES HOW PERSONAL MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

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," as it will further herein be referred. 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 a copy of this Notice of Privacy Practices upon request;
3. Notify you if there is a breach of your protected health information (PHI);
4. Notify you if there is a state law more stringent than the federal HIPAA law;
5. Comply with the terms of this Notice that is currently in effect.

We Have the Right to:
1. Change our privacy practices and terms 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

Authorization and Consent: Except as outlined below, we will not use or disclose your PHI for any purpose other than treatment, payment or healthcare operations unless you have signed a form authorizing such use or disclosure. You have the right to revoke such authorization in writing, with such revocation being effective as of the date we actually receive it in writing.

Uses and Disclosures for Treatment: We may use or disclose your PHI as necessary for your treatment to doctors, nurses and other professionals involved in your care, who may use information from your medical record and information that you provide about your symptoms and reactions to your course of treatment that may include procedures, medications, tests, medical history, etc.

Uses and Disclosures for Payment: We may use or disclose your PHI as necessary for payment purposes. During the normal course of business operations, we may forward information regarding your medical procedures and treatment to your insurance company, other business entity, or individual responsible for payment on your account, to arrange payment for the services provided to you.

Uses and Disclosures for Health Care Operations: We will use and disclose your PHI as necessary, and as permitted by law, for our health care operations, which may include clinical improvement, professional peer review, business management, accreditation and licensing, etc. For instance, we may use and disclose your PHI for purposes of improving clinical treatment and patient care.

Individuals Involved In Your Care: We may from time to time disclose your PHI to designated family, friends and others who are involved in your care or in payment for your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited PHI with such individuals without your approval. We may also disclose limited PHI to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

Business Associates: Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, outcomes data collection, legal services, etc. At times it may be necessary for us to provide your PHI to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these associates to appropriately safeguard the privacy of your information.

Appointments and Services: We may contact you to provide appointment updates or information about your treatment or other health-related benefits and services that may be of interest to you. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your PHI from us by alternative means or at alternative locations. For instance, if you wish appointment reminders to not be left on voice mail or sent to a particular number, we will accommodate reasonable requests to the best of our means. With such request, you must provide an appropriate alternative address or method of contact. You also have the right to request that we not send you any future marketing materials and we will use our best efforts to honor such request. You must make such requests in writing, including your name and address, and send such writing to us at the address below.

Research: In limited circumstances, we may use and disclose your PHI for research purposes. In all cases where your specific authorization is not obtained, your privacy will be protected by strict confidentiality requirements applied by an Institutional Review Board which oversees the research or by representations of the researchers that limit their use and disclosure of your information.

Other Uses and Disclosures: We are permitted or required by law to make certain other uses and disclosures of your protected health information without your consent or authorization for the following:

- Any purpose required by law;
- Public health reporting for immunizations, disease, injury, birth and death, or in connection with public health investigations;
- To law enforcement if we suspect you or a child is the victim of abuse, neglect or domestic violence;
- To the Food and Drug Administration to report adverse events, product defects, or to participate in product recalls;
- To your employer when we have provided health care for which you are seeking employee benefits;
- To a government oversight agency conducting audits, investigations, civil or criminal proceedings;

- Court or administrative ordered subpoena or discovery request;
- To coroners and/or funeral directors consistent with law;
- If necessary to arrange an organ or tissue donation from you or a transplant for you;
- If you are a member of the military, we may release your PHI for national security or intelligence activities; and
- To workers' compensation agencies and your employer for workers' compensation benefit determination.

DISCLOSURES REQUIRING YOUR DIRECT AUTHORIZATION:

The following uses and disclosures will be made only with your specific consent, 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 action based on this authorization.

Psychotherapy Notes: We must obtain your specific written authorization to disclose any psychotherapy notes unless otherwise permitted by law. However, there are certain purposes for which we may disclose psychotherapy notes, without obtaining your written authorization, including the following: (1) to carry out certain treatment, payment or healthcare operations (e.g., use for the purposes of your treatment, for our own training, and to defend ourselves in a legal action or other proceeding brought by you), (2) to the Secretary of the Department of Health and Human Services to determine our compliance with the law, (3) as required by law, (4) for health oversight activities authorized by law, (5) to medical examiners or coroners as permitted by state law, or (6) for the purposes of preventing or lessening a serious or imminent threat to the health or safety of you or another person or the public.

Genetic Information: We must obtain your specific written authorization prior to using or disclosing your genetic information for treatment, payment or health care operations purposes. We may use or disclose your genetic information, or the genetic information of your child, without your written authorization only where it would be permitted by law.

Marketing: We must obtain your authorization for any use or disclosure of your PHI for marketing, except if your consent is in the form of (1) face-to-face communication with you, or (2) a promotional gift of nominal value initiated by our office.

Sale of Protected Information: We must obtain your authorization prior to receiving direct or indirect remuneration in exchange for your health information; however, such authorization is not required where the purpose of the exchange is for:

- Public health activities;
- Research purposes, provided that we receive only a reasonable, cost-based fee to cover the cost to prepare and transmit the information for research purposes;
- Treatment and payment purposes;
- Healthcare operations involving the sale, transfer, or consolidation of all or part of our business and for related due diligence;
- Payment we provide to a business associate for activities involving the exchange of PHI that the business associate undertakes on our behalf (or the subcontractor undertakes on behalf of a business associate) and the only remuneration provided is for the performance of such activities;
- Providing you with a copy of your health information or an accounting of disclosures;
- Disclosures required by law;
- Disclosures of your health information for any other purpose permitted by and in accordance with the Privacy Rule of HIPAA, as long as the only remuneration we receive is a reasonable, cost-based fee to cover the cost to prepare and transmit your health information for such purpose or is a fee otherwise expressly permitted by other law; or
- Any other exceptions allowed by the Department of Health and Human Services.

3. YOUR INDIVIDUAL RIGHTS REGARDING YOU PHI (PROTECTED HEALTH INFORMATION):

- You may inspect or 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 or sent via electronic means as is notably accepted. We may require that this request be made via a special request form signed by you or your legal representative, and photo identification may be required. If your record is only maintained in electronic format, we may reduce the record to paper format or transfer via electronic means if possible. We will assess a fee for reproducing and sending your record. All reproduced records will be distributed via regular mail to the address in the request, or by accepted electronic means as specifically noted in the signed request, within 10 business days of receipt of request and payment.
- You may request a list of disclosures of your PHI 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.
- You may 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).
- Receive notification of a breach or potential breach of your PHI, and what steps you may need to take to further protect your information.
- 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 W. 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 at the following address. We will not retaliate or take action against you for filing such a complaint.

Office for Civil Rights Department of HHS, Jacob Javits Federal Building 26 Federal Plaza - Suite 3312 New York, NY 10278
PH (212) 264-3313 | FAX (212) 264-3039 | TDD (212) 264-2355

FOR FURTHER INFORMATION OR QUESTIONS, YOU MAY CONTACT OUR OFFICE AT THE ADDRESS NOTED ABOVE. THIS NOTICE IS ALSO AVAILABLE ON OUR PUBLIC WEBSITE AT: WWW.HOWARDPLASTICSURGERY.COM.

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 January 17, 2013, and have been provided an opportunity to review it.

_____
Printed Name of Patient or Legal Guardian

_____
Signature

_____
Date

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