

## WEISS ORTHOPAEDICS

# 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 AND SIGN THE FINAL PAGE.**

Effective Date: **April 14, 2003**

Revised as of: September 23, 2013

This Notice of Privacy Practices describes how we, our Business Associates, and their subcontractors, may use and disclose your Protected Health Information to carry out treatment, payment or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. We are required by law to maintain the privacy of "Protected Health Information" and give you this Notice. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related healthcare services.

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

Your protected health information 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 healthcare services to you, to pay your healthcare bills, to support the operation of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your healthcare with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

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

**Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at 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, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

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 issues as required by law;
- Communicable diseases;
- Health oversight;
- Abuse or neglect;
- Food and drug administration requirements;
- Legal proceedings;
- Law enforcement;
- Coroners;
- Funeral directors;
- Organ donation;
- Research;
- Criminal activity;
- Military activity and national security;
- Workers' compensation;
- Inmates; and
- Other required uses and disclosures.

Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

#### **USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION**

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization, or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

**You may revoke the 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.

#### **YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION**

The following are statements of your rights with respect to your protected health information.

##### **You have the right to inspect and copy your protected health information (fees may apply)**

Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

##### **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 your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

**You have the right to request to receive confidential communications**

You have the right to request 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.

**You have the right to request an amendment to your protected health information**

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**

You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

**You have the right to receive notice of a breach**

We will notify you if your unsecured protected health information has been breached.

**You have the right to obtain a paper copy of this notice** from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice. We will also make available copies of our new notice if you wish to obtain one.

**COMPLAINTS**

You may file a complaint with us or with the Secretary of Health and Human Services if you believe your privacy rights have been violated. We will not retaliate against you for filing a complaint.

Weiss Orthopaedics HIPAA Privacy Officer  
**Charles Linch**  
**357 Perkins St,**  
**Sonoma Ca 95476**  
**707.935.5600**

Secretary of the U.S. Department of Health  
and Human Services  
Office of Civil Rights  
200 Independence Avenue, S.W.  
Washington D.C. 20201  
(202) 619 – 0257  
Toll Free: 1 (877) 696 – 6775

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Privacy Officer. Please sign the accompanying “Acknowledgment” form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

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## **Notice of Privacy Practices Acknowledgement Form**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

### **OFFICE USE ONLY**

I attempted to obtain the patient's signature in acknowledgment on the Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date: \_\_\_\_\_ Initials: \_\_\_\_\_ Reason: \_\_\_\_\_