**Purpose**

To ensure that a *Notice of Privacy Practices* is provided to, and acknowledged by, each Patient or his/her personal representative no later than the date of the first service delivery.

Policy

[COVERED ENTITY] will provide a Notice of Privacy Practices (“Notice”) to each Patient on the date of the first service delivery and will make a good faith effort to obtain a signed Acknowledgement of Receipt of Notice of Privacy Practices (“Acknowledgement”)from the Patient.

The Notice shall include all elements and statements that are required by law. The Notice shall inform the Patients of:

* Uses and disclosures of Protected Health Information (“PHI”) that may be made by [COVERED ENTITY];
* The Patient’s rights with respect to his PHI; and
* [COVERED ENTITY]’s legal duties with respect to such PHI.

Procedure

1. The Notice and Acknowledgementforms will be included in the standard new patient packet.
2. [COVERED ENTITY] Staff will provide the Noticeto the patient at the time of the patient’s appointment or registration.

**Note:** In the case of an emergency treatment situation, [COVERED ENTITY] will provide the Notice to the patient as soon as reasonably practicable after the emergency treatment situation.

1. [COVERED ENTITY] will make a good faith effort to obtain the patient’s signature on the Acknowledgementat the time the Noticeis provided.
2. The Notice and signed Acknowledgement will be kept in the patient’s medical record.
3. If the Patient refuses or is otherwise unable to sign the Acknowledgement, staff will document, on the Acknowledgementform, what actions were taken to obtain the patient’s signature on the Acknowledgement and the reason(s) why a signed Acknowledgement was not obtained. This document will then be placed in the patient’s medical record.
4. [COVERED ENTITY] will provide a copy of the written Notice to patients and to other persons upon request.
5. [COVERED ENTITY] will post a copy of the Notice in a clear and prominent location such as the entrance lobby or similar location.
6. A current version of the Noticewill be maintained on [COVERED ENTITY]’s website, if any.
7. Whenever the Notice is revised, [COVERED ENTITY] Privacy Officer will ensure that:
	1. The revised Notice is made available upon request on or after the effective date of the revision; and
	2. The revised Notice is postedin a clear and prominent location.
8. Material changes shall not be implemented prior to the effective date of the revised Notice.
9. A copy of each Notice issued by [COVERED ENTITY] will be maintained for at least six years from the date it was last in effect.
10. Any member of the workforce who has knowledge of a violation or potential violation of this Policy must make a must make a report directly to the Privacy Officer.

**NOTICE OF PRIVACY PRACTICES**

**THIS NOTICE OF PRIVACY PRACTICES (“NOTICE”) DESCRIBES HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION AND HOW YOU CAN GET ACCESS TO SUCH INFORMATION. PLEASE READ IT CAREFULLY.**

**ABOUT THIS NOTICE**

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates, and our Business Associates’ subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care 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.

“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 health care services.

We are required by the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and other applicable laws to maintain the privacy of your health information, to provide individuals with this Notice of our legal duties and privacy practices with respect to such information, and to abide by the terms of this Notice. We are also required by law to notify affected individuals following a breach of their unsecured health information.

**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 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.

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 health care 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 health care 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 who 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 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 from using or disclosing 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**

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 i.e. electronically.

**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 will also make available copies of our new notice if you wish to obtain one.

**We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment.**

**COMPLAINTS**

You may complain to us or to the Secretary 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 Compliance Officer of your complaint. We will not retaliate against you for filing a complaint.

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 Compliance Officer in person or by phone at our main phone number.

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.

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_

**ACKNOWLEDGMENT OF RECEIPT OF**

**NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have received a copy of [COVERED ENTITY]’s “Notice of Privacy Practices” for protected health information on the date set forth below.

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Date of Receipt Patient Date of Birth

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Patient Name Authorized Personal Representative

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Signature of Authorized Personal Representative

FOR USE BY [COVERED ENTITY] PERSONNEL ONLY (complete if patient acknowledgement is not obtained)

An Acknowledgment of Receipt of Notice of Privacy Practices was not received because:

\_\_\_\_\_\_ Patient refused to sign Acknowledgment

\_\_\_\_\_\_ Unable to gain signed Acknowledgment due to communication / language or other barrier

\_\_\_\_\_\_ Patient was unable to sign Acknowledgment due to emergency treatment situation

\_\_\_\_\_\_ Other (please indicate reason):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of [COVERED ENTITY] Representative Date