

## 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.

### Internal Medicine Associates of Plano, PA

#### Uses and Disclosures

*Treatment.* Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedure will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

*Payment.* Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

*Health care operations.* Your health information may be used as necessary to support the day-to-day activities and management of medical claims, billing, and other administrative duties. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

*Law enforcement.* Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

*Public health reporting.* Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

To prevent or control disease, injury, or disability;

- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and
- To notify the appropriate government authority if we believe you have been the victim of abuse, neglect, or domestic violence.

All such disclosures will be made in accordance with the requirements of Texas and federal laws and regulations

*Other uses and disclosures require your authorization.* Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the

authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

### **Additional Uses of Information**

*Appointment reminders.* Your health information will be used by our staff to send you appointment reminders by email, text, web portal or to contact you by phone regarding appointment reminders.

*Information about treatments.* Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

### **Individual Rights**

You have certain rights under the federal privacy standards. These include:

1. The right to request restrictions on the use and disclosure of your Protected Health Information;
2. The right to receive confidential communications concerning your medical condition and treatment;
3. The right to inspect and copy your Protected Health Information;
4. The right to amend or submit corrections to your protected health information;
5. The right to receive an accounting of how and to whom your protected health information has been disclosed; and
6. The right to receive a printed copy of this notice.

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

### **Right to Revise Privacy Practices**

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

### **Requests to Inspect Protected Health Information**

As permitted by federal regulation, we require that requests to inspect or copy Protected Health Information be submitted in writing. You may obtain a form to request access to your records by contacting: **Jennifer Beck, Internal Medicine Associates, PA Privacy Officer, Internal Medicine Associates of Plano, PA, 6124 W. Parker Rd. Ste 234 Plano, TX 75093 972-981-7500.**

### **Complaints**

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter and outlining your concerns to Internal Medicine Associates of Plano, Attn: HIPAA Privacy Officer 6124 W. Parker Road Suite 234 Plano, TX 75093.

If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at Internal Medicine Associates of Plano, 972-981-7500 or with the Office for Civil Rights,

U.S. Department of Health and Human Services. To file a complaint with Internal Medicine Associates of Plano, contact the Privacy Officer at 972-981-7500. Your complaint must be filed within 180 days of when you knew or should have known that the act occurred.

The address for the Office of Civil Rights is:

***Secretary of Health & Human Services Region VI, Office for Civil Rights  
U.S. Department of Health and Human Services  
1301 Young Street, Suite 1169  
Dallas, TX 75202***

All complaints should be submitted in writing.

***You will NOT be penalized for filing a complaint.***

**Effective Date**

This Notice is effective on or after January 1, 2008.

**Acknowledgment Form**

I acknowledge receipt of this Notice of Privacy Rights which I have reviewed and give my permission to \_\_\_\_\_ to use and disclose my health information in accordance with it.

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

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

I give permission to \_\_\_\_\_ to release medical information to the following person(s):  
(Please print names below).

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

**This Authorization will expire in two (2) years from the above date unless written revocation is received.**

**Documentation of Patient's Refusal to Sign  
Acknowledgment Form**

On this date, I reviewed with \_\_\_\_\_ the practice's Notice of Privacy Rights and answered any questions regarding the Notice. I then requested that the patient sign the Acknowledgment Form. The patient refused to sign the Acknowledgment Form.

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\_\_\_\_\_  
**Signature of Staff Member**

\_\_\_\_\_  
**Name of Staff Member (Print)**

\_\_\_\_\_  
**Date**