

Notice Of Privacy Practices



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- The **revised** effective date of this version of the **Notice of Privacy Practices** is **September 28, 2025**.
- This version supercedes all previous versions.
- 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.**

## **NOTE:**

1. The **name of my practice** is **Timothy M. Fishback, M.D.**
2. I meet HIPAA's standards as a "covered entity," which means that HIPAA's rules and regulations apply to me.
3. I work alone and employ no staff, so I also serve the HIPAA-mandated roles of Privacy Official and Security Officer.
4. I respect your privacy. I maintain records containing your personal health information that are protected by law.
5. This **Notice of Privacy Practices** explains:
  - How I may use or disclose your protected health information
  - Your rights
  - My legal duties regarding your protected health information

In this **Notice**, your **protected health information** is referred to as your "**Health Information**".

## **My Duties Regarding Your Health Information**

I am required by law to maintain the privacy of your Health Information and provide you with this Notice of my legal duties and privacy practices with respect to your Health Information and notify you if there is a breach of your unsecured Health Information. I reserve the right to change my privacy practices and the terms of this Notice and make the provisions of a revised Notice effective for all your Health Information I maintain.

If I revise the Notice, I will provide it to you when it is in effect:

- By posting it in a clear and prominent location in my waiting room
- Making a copy available for you to request
- Making a copy available in the waiting room for you to take with you, without having to ask
- Posting it on my website

I must follow the terms of the Notice that is ***in effect*** (i.e, the latest revision). You may request a copy of the Notice at any time, and I will provide you with a copy of the Notice that is in effect at the time of your request.

You may contact me if you have any questions or would like further information about the matters covered by this Notice:

- The best way to reach me is via secure messaging in your patient portal (MYIO)
- You may also find my contact information in the header of this document
- You will see my contact information at the end of this Notice

## How I May Use And Disclose Your Health Information

### Use and Disclosure of Your Health Information for Treatment, Payment, and Health Care Operations

I am permitted to use and disclose your Health Information for purposes of treatment, payment, and health care operations.

1. **Treatment.** I may use or disclose your Health Information to provide you with health care treatment or services. For example, I may use your Health Information to diagnose and treat you, or I may disclose your Health Information to a healthcare provider you may be referred to, so the provider has the necessary information to diagnose or treat you.
2. **Payment.** I may use or disclose your Health Information to obtain payment or be reimbursed for the health care treatment and services I provide. For example, I may give your Health Information to your health plan so it can reimburse you or pay me. I may also provide your Health Information to your health plan to obtain prior approval for treatment or to determine whether your plan will cover the treatment.
3. **Health Care Operations.** I may use or disclose your Health Information in connection with my healthcare operations, which are the ways I provide healthcare and manage my practice. For example, I may use or disclose your Health Information to evaluate my performance in delivering healthcare to you and identify ways I can improve my service.

### Use and Disclosure of Your Health Information Required or Permitted by Law

There are situations, in addition to treatment, payment, and healthcare operations, where I may use or disclose some of your Health Information without obtaining your written

authorization. Any such use or disclosure will be limited to your Health Information required or permitted by law in the following situations.

1. **Public Health.** I may disclose your Health Information to public health authorities authorized by law to collect or receive information to report vital information and prevent or control disease or injury. For example, I may report information about communicable diseases, child abuse or neglect, problems related to food, medications, medical devices or products, and vital events such as births or deaths. I may also disclose your Health Information to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition, or findings concerning a work-related illness or injury, or workplace-related health issue, to an employer. Suppose I reasonably believe you are a victim of abuse, neglect, or domestic violence. In that case, I may disclose your Health Information, limited to requirements of law, to a government authority, including a social service or protective services agency authorized by law to receive reports of such abuse, neglect, or domestic violence.
2. **Health Oversight Activities.** I may disclose your Health Information to a health oversight agency, which includes, among others, an agency of the federal or state government authorized by law to monitor the healthcare system. Authorized health oversight activities include audits, civil, administrative, or criminal investigations, inspections, licensure or disciplinary actions, and other activities necessary for the appropriate oversight of the healthcare system.
3. **Judicial and Administrative Proceedings.** I may disclose your Health Information in the course of judicial or administrative proceedings. For example, I disclose in response to a court or administrative order or subpoena.
4. **Law Enforcement Purposes.** I may disclose your Health Information to a law enforcement official as required by law in response to a law enforcement official's lawful request to identify or locate a victim, suspect, fugitive, material witness, or missing person or to report a crime that has occurred on my premises or that may have caused a need for emergency services.
5. **Required by Law.** I may use or disclose your Health Information when required by state, federal, or other laws to correctional institutions, the Food and Drug Administration, and authorized federal officials for the conduct of lawful national security activities and the provision of protective services to the President or other persons as required by federal law.
6. **Coroners, Medical Examiners, and Funeral Directors.** I may disclose your Health Information to coroners or medical examiners to identify a deceased person or to determine the cause of death, and to funeral directors as necessary to carry out their duties.
7. **Organ Donation.** I may disclose your Health Information to an organ procurement organization or other facility that participates in or makes a determination for the procurement, banking, or transplantation of organs or tissues.
8. **Research.** I may use or disclose your Health Information for research purposes under strict legal protection only if the use or disclosure has been reviewed and approved by a special Privacy Board or Institutional Review Board, or if you authorize the use or disclosure.

9. **Disaster Relief Incidents.** I may use or disclose your Health Information to a public or private entity authorized to assist in disaster relief efforts, such as the American Red Cross. If you tell me that you object, I will not make this use or disclosure unless I must do so to respond to an emergency situation.
10. **Persons Involved in Your Care.** I may use or disclose your Health Information to persons involved in your health care or payment for health care, including family members, your personal representative, or another person identified by you, unless you object to my use and disclosure of your Health Information to such persons.
11. **Workers Compensation.** I may use or disclose your Health Information to comply with workers' compensation laws.
12. **Avert a Serious Threat to Health or Safety.** I may use or disclose your Health Information if I believe it is necessary to prevent or lessen a serious threat to the health or safety of a person or the public.
13. **School Immunization Records.** I may disclose your Health Information to provide proof of your immunization to a school if you are an adult or emancipated minor and you agree; or about a minor child if the child's parent or guardian agrees.
14. **Military.** If you are a member of the armed forces, I may release medical information about you to military authorities as authorized or required by law. I may also release medical information about foreign military personnel to the appropriate foreign military authority.
15. **Business Associates.** I may use entities that are called Business Associates to perform work or services for my practice, such as legal, accounting, or financial services, where the Business Associate may be required to create, receive, maintain, or transmit your Health Information, but only if the Business Associate first agrees by written contract to safeguard your Health Information as is required by law.
16. **Fundraising.** I may use limited Health Information such as your name, address, and treatment dates to contact you for fundraising purposes to support my healthcare purposes and mission. You have the right to elect not to receive fundraising communications, and if you receive a fundraising communication from me, you will also receive simple instructions about how to stop receiving any more fundraising communications.

## Use And Disclosure Of Your Health Information Requiring Written Authorization

Your written authorization is required for the following uses and disclosures of your Health Information:

1. **Marketing.** I will not use or disclose your Health Information for marketing purposes without your written authorization. Marketing is a form of communication about a product or service related to your healthcare, for which I receive payment from a third party.
2. **Sale of your Health Information.** I will not use or disclose your Health Information in a way that is considered a sale of your Health Information without your written authorization. A sale of your Health Information is defined as an exchange where I, directly or indirectly, receive payment for your Health Information from the recipient of

your Health Information.

3. **Psychotherapy Notes.** If I maintain psychotherapy notes about you, I will not disclose psychotherapy notes without your written authorization except in limited instances that are permitted or required by law.

## **All Other Uses And Disclosures Of Your Health Information Require Written Authorization**

Your written authorization is required for uses and disclosures of your Health Information not described in this Notice.

## **You May Revoke an Authorization in Writing at Any Time**

You may revoke an authorization to use or disclose your Health Information anytime. Your revocation must be in writing, and it will not affect uses or disclosures of your Health Information made in reliance on your authorization before its revocation. Suppose the Authorization was obtained as a condition of obtaining insurance coverage. In that case, other laws may provide the insurer with the right to contest a claim under the policy or the policy itself.

# **Your Right Regarding Your Health Information**

This section explains your rights and how you can make use of your rights regarding your Health Information.

## **Your Right to My Notice of Privacy Practices**

You have the right to obtain a paper copy of my current Notice of Privacy Practices. You have the right to receive an electronic copy of this Notice from my website if I maintain one or, if you agree in writing, by email. You have the right to obtain a paper copy of this Notice at any time, even if you have agreed to receive it electronically. You may request that I, in my role as the HIPAA-mandated Privacy Official, provide you with a copy of my current Notice at any time. My contact information is at the end of this notice.

## **Your Right to Request Restrictions of Use and Disclosure of Your Health Information**

### **Your General Right to Request Restrictions - I Am Not Required to Agree**

- You have the right to request a restriction of your Health Information I use or disclose for your treatment, for payment of your health care services, or activities related to my health care operations. You may also request a restriction on what Health Information I may disclose to someone involved in your care or payment for your care, like a family member or friend. Your request must be in writing and given to my Privacy Official, whose contact

information is at the end of this Notice. I will provide you with the form to make your written request. I am not required to agree to your request. If I agree, I will comply with your request unless the information is needed to provide you with emergency treatment, and I will request that health care providers not further use or disclose your Health Information. I may terminate my restriction if you ask us to terminate it. I may also terminate a restriction whether or not you ask us to end the restriction if I inform you I am terminating it. If I do terminate a restriction, it will only affect your Health Information that was created or received after I inform you of the termination.

### **Your Right to Request I Not Disclose Your Health Information to Your Health Plan (Health Insurance Provider) - I Must Agree Under Certain Conditions**

- You have the right to request that I not disclose your Health Information to your health plan (your health insurance provider) if the disclosure:
  1. is to carry out payment or health care operations,
  2. is not otherwise required by law, and
  3. pertains solely to a health care item or service for which you or someone other than the health plan on your behalf has paid for in full.
- Your request must be in writing and given to my Privacy Official, whose contact information is at the end of this Notice. I will provide you with the form to make your written request. I must agree to your request if all three conditions listed above are present.

### **Your Right to Request Confidential Communications**

- You have the right to request that I communicate with you about your Health Information by alternative means or at an alternative location. For example, you can ask that I only contact you by telephone at work or by mail in a sealed envelope (not a postcard). I will not ask you the reason for your request, and I will accommodate all reasonable requests. If I cannot communicate with you by alternative means or at the alternative location you have requested, I may attempt to communicate with you using any information I have. Your request must be in writing and given to my Privacy Official, whose contact information is at the end of this Notice. I will provide you with the form to make your written request.

### **Your Right to Inspect and Copy Your Health Information**

- You have the right to inspect and copy your Health Information I maintain that may be used to make decisions about your treatment and care, including billing records for as long as I maintain the information. You may also request an electronic copy of your Health information if I maintain it electronically. Your request must be in writing and given to my Privacy Official, whose contact information is at the end of this Notice. I will provide you with the form to make your written request and provide access to your Health Information except in some limited circumstances. If I deny any part of your request, I will explain in writing why I made the denial, if and how you may request a review of my

denial and how you may make a complaint to us and the Secretary of the U.S. Department of Health and Human Services about my denial. I may charge a reasonable, cost-based fee for making copies of your Health Information and sending the copies to you, including costs of labor, supplies and postage. I will not charge a fee if you only view and inspect your Health Information at a convenient time and place.

### **Your Right to Request Amendment of your Health Information**

- If you believe your Health Information I maintain is incorrect or incomplete, you have the right to request that I correct (amend) the Health Information. Your request must be in writing and given to my Privacy Official, whose contact information is at the end of this Notice. I will provide you with the form to make your written request. I will inform you of my action on your request, including what I will do if I accept your request for amendment in whole or in part. If I deny all or part of your request for amendment, I will provide the reasons for the denial and inform you of your additional rights regarding my denial, including your right to complain to us and the Secretary of the U.S. Department of Health and Human Services.

### **Your Right to an Accounting of Disclosures of Your Health Information**

- You have the right to receive a list (accounting) of certain disclosures of your Health Information I have made. Your request for an accounting of these disclosures must be in writing and given to my Privacy Official, whose contact information is at the end of this Notice. I will provide you with the form to make your written request, and I will provide you with the accounting in writing. You may request an accounting of disclosures for up to six (6) years before the date you make the request. I will provide the accounting free of charge. If you request an accounting more than once in a twelve (12) month period, I may charge you a reasonable, cost-based fee for providing another accounting, but first, I will let you know what the cost would be so you can modify your request to reduce the fee or withdraw it.

### **Your Right to Make a Complaint that Your Privacy Rights Have Been Violated**

- If you believe your privacy rights have been violated, you have the right to file a complaint with us and with the Secretary of the U.S. Department of Health and Human Services. I will not retaliate against you for filing a complaint that your privacy rights have been violated. You may file a complaint with us by contacting the office of my Privacy Official listed below. Information about making a complaint to the Secretary is provided below.

## **Contact Information**

**Timothy M. Fishback, M.D.**

For more information about the matters covered by this Notice, your health information rights, or to complain that your privacy rights have been violated, please get in touch with me. If you wish, I will provide you with a form to submit a written complaint. I will not retaliate against you

for filing a complaint that your privacy rights have been violated.

- Privacy Official of Timothy M. Fishback, M.D.
- Telephone: (760) 567-9522
- Office address: 3022 N Avenida Caballeros, Palm Springs, CA 92262

## Secretary, U. S. Department of Health and Human Services

You may make a health information privacy or security complaint to the Secretary of the U.S. Department of Health and Human Services (HHS). I will not retaliate against you for making the complaint. A complaint to HHS must be filed within 180 days of when you first knew of the reasons you believe your health information privacy rights were violated, although the 180 days can be extended if you can show "good cause."

If you have any questions about how to file a complaint, you may contact the Department of Health and Human Services, Office for Civil Rights Customer Response Center at 1-800-368-1019 (voice) or TDD: 1-800-537-7697. You may also send an email message to [OCRMail@hhs.gov](mailto:OCRMail@hhs.gov) or fax to (202) 619-3818.

**Signature:** \* **x** \_\_\_\_\_

**Date:**