VERDE COMMUNITY HEALTHCARE

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HIPAA 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.

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) TO CARRY OUT TREATMENT, PAYMENT OR HEALTH CARE OPERATION (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, PRESEENT OR FUTURE PHYSICAL OR MENTAL HEALTH OR CONDITION AND RELATED HEALTH CARE 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 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 OF MANAGEMENT OF YOUR HEALTH CARE WITH A THIRD PARTY. FOR EXAMPLE, WE WOULD DISCLOSE YOUR PROTECTED HEALTH INFORMATION, AS NECESSARY TO A HOME HEALTH AGENCY THAT PROVIDES CARE FOR YOU.

PAYMENT: YOUR PROTECTED HEALTH INFORMATION WILL BE USED, AS NEEDED, TO OBTAIN PAYMENT FOR YOUR HEALTH CARE SERVICES.

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 OF BUSINESS ACTIVITIES. FOR EXAMPLE WE MAY DISCLOSE YOUR PROTECTED HEALTH INORMATION TO MEDICAL STUDENTS THAT SEE PATIENTS AT OUR OFFICE. WE MAY USE A SIGN IN SHEET AT THE REGISTRATION DESK. WE MAY CALL YOU BY NAME WHEN THE DOCTOR IS READY TO SEE YOU.

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 AND ORGAN DONATION: RESEARCH: CRIMINAL ACTIVITY: MILITARY ACTIVITY AND NATIONAL SECURITY: WORKERS COMPENSATION: INMATES: REUIRED USERS AND DISCLOSURES: UNDER THE LAW, WE MUST MAKE DISCLOSURES TO YOUR AND WHEN REQUIREMENTS OF SECTION 164-500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, UNLESS REQUIRED BY LAW.

YOU MAY REVOKE THIS AUTHORIZATION, AT ANY TIME, IN WRITING, EXCEPT TO THE EXTENT THAT YOUR PHYSICIAN OR THE PHYSICIAN'S PRACTICE HAS TAKEN ACTION IIN RELIANCE ON THE USE OR DISCLOSURE INDICATED IN THE AUTHORIZATION.

YOUR RIGHTS: FOLLOWING IS A STATEMENT OF YOUR RIGHTS WITH RESPECT TO YOUR PROTECTED HEALTH CARE.

YOUHAVE THE RIGHT TO REQUEST A RESTRICTION OF YOUR PROTECTED HEALTH CARE INFORMATION. THIS MEANS YOU MAY ASK US NOT TO USE OR DISCLOSE ANY PART OF YOUR PROTECTED HEALTH INFORMATION FOR THE PURPOSE OF TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS. YOU MAY ALSO REQUEST THAT ANY PART OF YOUR PROTECTED HEALTH INFORMATION NOT BE DISCLOSED TO FAMILY OR FRIENDS WHO MAY BE INVOLVED IN YOUR CARE OR FOR NOTIFICATION PUROOSES AS DESCRIBED IN THIS NOTICE OF PRIVACY PRACTICES. YOUR REQUEST MUST STATE THE SPECIFIC RESTRICTION AND TO WHOM YOU WANT THE RESTRICTION TO APPLY.

YOUR PHYSICIAN IS NOT REQUIRED TO AGREE TO A RESTRICTION THAT YOU MAY REQUEST. IF YOUR PHYSICIAN BELIEVES IT IS IN YOUR BEST INTEREST TO PERMIT USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION YOUR PROTECTED HEALTH INFORMATION WILL NOT BE RESTRICTED. YOU THEN HAVE THE RIGHT TO USE ANOTHER HEALTH CARE PROFESSIONAL.

YOU HAVE THE RIGHT TO REQUEST TO RECEIVE CONFIDENTIAL COMMUNICATIONS FROM US BY ALTERNATIVE MEANS OR AT AN ALTERNATIVE LOCATION. YOU HAVE THE RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE FROM US EVEN IF YOU HAVE AGREED TO ACCEPT THIS NOTICE ELECTRONICALLY.

YOU MAY HAVE THE RIGHT TO HAVE YOUR PHYSICIAN AMEND YOUR PROTECTED HEALTH INFORMATION.

IF WE DENY YOUR REQUEST FOR AMENDMENT, YOU HAVE THE RIGHT TO FILE A STATEMENT OF DISAGREEMENT WITH US AND WWE MAY PREPARE A REBUTTAL TO YOUR STATEMENT AND WILL PROVIDE YOU WITH A COPY OF SUCH REBUTTAL.

YOU HAVE THE RIGHT TO RECEIVE AN ACCOUNTING OF CERTAIN DISCLOSURES WE HAVE MADE, IF ANY, OF YOUR PROTECTED HEALTH CARE INFORMATION.

WE RESERVE THE RIGHT TO CHANGE THE TERMS OF THIS NOTICE AND WILL INFORM YOU BY MAIL OF ANY CHANGES. YOU THEN HAVE THE RIGHT TO OBJECT OR WITHDRAW AS PROVIDED BY THIS NOTICE.

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 PRIVACY CONTACT OF YOUR COMPLAINT. **WE WILL NOT RETALIATE AGAINST YOU FOR FILING A COMPLAINT.**

THIS NOTICE WAS PUBLISHED AND BECOMES EFFECTIVE ON OR BEFORE APRIL 14, 2003

WEW 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. IF YOU HAVE ANY OBJECTIONS TO THIS FORM, PLEASE ASK TO SPEAK WITH OUR HIPPA COMPLIANCE OFFICER IN PERSON OR BY PHONE.

SIGNATURE BELOW IS ONLY AN ACKNOWLEDGMENT THAT YOU HAVE RECEIVED THIS NOTICE OF OUR PRIVACY PRACTICES.

PATIENT COPY