

## THRIVE MEDICAL LLC

### NOTICE OF PRIVACY PRACTICES

#### Your Information. Your Rights. Our Responsibilities.

THIS NOTICE OF PRIVACY PRACTICES (“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.

We are required by law to protect the privacy of health information that may reveal your identity, and to provide you with a copy of this Notice which describes the health information privacy practices of Thrive Medical LLC. A copy of our current Notice will always be posted in our reception area. You will also be able to obtain your own copy by calling the Thrive Medical LLC at 407-634-2104 or asking for one at the time of your next visit.

*If you have any questions about this Notice or would like further information, please contact Melissa Odom, APRN at 407-634-2104.*

#### **WHAT HEALTH INFORMATION IS PROTECTED**

We are committed to protecting the privacy of information we gather about you while providing health-related services. Some examples of protected health information are:

- information indicating that you are a patient or receiving treatment or other health-related services from us;
- information about your health condition (such as a disease you may have);
- information about health care products or services you have received or may receive in the future; or
- information about your health care benefits under an insurance plan;

*when combined with:*

- demographic information (such as your name, address, or insurance status);
- unique numbers that may identify you (such as your social security number, your phone number, or your driver’s license number); or
- other types of information that may identify who you are.

#### **REQUIREMENT FOR WRITTEN AUTHORIZATION**

We will obtain your written authorization before using your health information or sharing it with others outside Thrive Medical LLC, except as we describe in this Notice. Uses and disclosures of health information that require your written authorization include: most uses and disclosures of psychotherapy notes, most uses and disclosures of protected health information for marketing purposes, and disclosures that constitute a sale of protected health information. Other uses and disclosures not described in this Notice or otherwise permitted by HIPAA will be made only with your written authorization. You

may also initiate the transfer of your records to another person by completing a written authorization form. If you provide us with written authorization, you may revoke that written authorization at any time, except to the extent that we have already relied upon it. To revoke a written authorization, please write to Melissa Odom, APRN at 2200 Winter Springs Blvd. #106-265 Oviedo, FL 32765.

## **HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR WRITTEN AUTHORIZATION**

There are some situations when we do not need your written authorization before using your health information or sharing it with others. They are:

### **1. Treatment, Payment, and Health Care Operations.**

*Thrive Medical LLC may use your health information or share it with others in order to provide health care services to you, obtain payment for those services, and run Thrive Medical LLC's normal business operations. Your health information may also be shared with your other health care providers so that they may jointly perform certain payment activities and business operations along with our medical practice. In some cases, we may also disclose your health information for payment activities and certain business operations of another health care provider or payor. Below are further examples of how your information may be used and disclosed for these treatment, payment, and normal business operations without your written authorization.*

**Treatment.** We may share your health information with health care providers in our Thrive Medical LLC who are involved in taking care of you, and they may in turn use that information to diagnose or treat you. A health care provider in our Thrive Medical LLC may share your health information with another health care provider inside our Thrive Medical LLC, or with someone at another hospital or medical practice, to determine how to diagnose or treat you. Your health care provider may also share your health information with another health care provider to whom you have been referred for further health care.

**Payment.** We may use your health information or share it with others so that we obtain payment for your health care services. For example, we may share information about you with your health insurance company if applicable in order to obtain reimbursement after we have treated you. In some cases, we may share information about you with your health insurance company to determine whether it will cover your treatment.

**Health Care Operations.** We may use your health information or share it with others in order to conduct our business operations. For example, we may use your health information to evaluate the performance of our staff in caring for you, or to educate our staff on how to improve the care they provide for you.

**Appointment Reminders, Treatment Alternatives, Benefits and Services.** In the course of providing treatment to you, we may use your health information to contact you

with a reminder that you have an appointment for treatment or services. We may also use your health information in order to recommend possible treatment alternatives or health-related benefits and services that may be of interest to you.

**Business Associates.** We may disclose your health information to contractors, agents and other business associates who need the information in order to assist us with obtaining payment or carrying out our business operations. For example, we may share your health information with a billing company that helps us to obtain payment from your insurance company. Another example is that we may share your health information with an accounting firm or law firm that provides professional advice to us about how to improve our health care services and comply with the law. If we do disclose your health information to a business associate, we will have a written contract with our business associate that ensures that our business associate also protects the privacy of your health information.

2. **Friends and Family Involved In Your Care.** If you do not object, we may share your health information with a family member, relative, or close personal friend who is involved in your care or payment for that care.

3. **Emergencies or Public Need.**

**As Required By Law.** We may use or disclose your health information if we are required by law to do so. We also will notify you of these uses and disclosures if Notice is required by law.

**Public Health Activities.** We may disclose your health information to authorized public health officials (or a foreign government agency collaborating with such officials) so they may carry out their public health activities under law, such as controlling disease or public health hazards. We may also disclose your health information to a person who may have been exposed to a communicable disease or be at risk for contracting or spreading the disease if a law permits us to do so. We may also release your health information to government disease registries. And finally, we may release some health information about you to your employer if your employer hires us to provide you with a physical exam and we discover that you have a work-related injury or disease that your employer must know about in order to comply with employment laws.

**Victims of Abuse, Neglect, or Domestic Violence.** We may release your health information to a public health authority that is authorized to receive reports of abuse, neglect, or domestic violence.

**Health Oversight Activities.** We may release your health information to government agencies authorized to conduct audits, investigations, and inspections of our Thrive Medical LLC. These government agencies monitor the operation of the health care system, government benefit programs such as Medicare and Medicaid, and compliance with government regulatory programs and civil rights laws.

**Product Monitoring, Repair and Recall.** We may disclose your health information to a person or company that is regulated by the Food and Drug Administration for the purpose of: (1) reporting or tracking product defects or problems; (2) repairing, replacing, or recalling defective or dangerous products; or (3) monitoring the performance of a product after it has been approved for use by the general public.

**Lawsuits and Disputes.** We may disclose your health information if we are ordered to do so by a court or administrative tribunal that is handling a lawsuit or other dispute. We may also disclose your information in response to a subpoena, discovery request, or other lawful request by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain a court order protecting the information from further disclosure and only with a written certification by the party issuing the subpoena in accordance with law.

**Law Enforcement.** We may disclose your health information to law enforcement officials for certain reasons, such as complying with court orders, assisting in the identification of fugitives or the location of missing persons, or if necessary, to report a crime that occurred on our property.

**To Avert a Serious and Imminent Threat to Health or Safety.** We may use your health information or share it with others when necessary to prevent a serious and imminent threat to your health or safety, or the health or safety of another person or the public. In such cases, we will only share your information with someone able to help prevent the threat. We may also disclose your health information to law enforcement officers if you tell us that you participated in a violent crime that may have caused serious physical harm to another person, or if we determine that you escaped from lawful custody (such as a prison or mental health institution).

**National Security and Intelligence Activities or Protective Services.** We may disclose your health information to authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President or other important officials.

**Military and Veterans.** If you are in the Armed Forces, we may disclose health information about you to appropriate military command authorities for activities they deem necessary to carry out their military mission. We may also release health information about foreign military personnel to the appropriate foreign military authority.

**Inmates and Correctional Institutions.** If you are an inmate or you are detained by a law enforcement officer, we may disclose your health information to the prison officers or law enforcement officers, if necessary, to provide you with health care, or to maintain safety, security and good order at the place where you are confined. This includes sharing information that is necessary to protect the health and safety of other inmates or persons involved in supervising or transporting inmates.

**Workers' Compensation.** We may disclose your health information for workers' compensation or similar programs that provide benefits for work-related injuries.

**Coroners, Medical Examiners and Funeral Directors.** In the unfortunate event of your death, we may disclose your health information to a coroner or medical examiner. We may also release this information to funeral directors as necessary to carry out their duties consistent with applicable law.

**Organ and Tissue Donation.** In the unfortunate event of your death, if you are an organ donor, we will disclose your health information to organizations involved in organ donation, organ and tissue procurement and transplantation, as necessary to facilitate organ, tissue or eye donation and transplantation.

**Research.** Under some circumstances, we may use and disclose your health information without your written authorization if we obtain approval through a special process to ensure that research without your written authorization poses minimal risk to your privacy. Under no circumstances, however, would we allow researchers to use your name or identity publicly. We may also release your health information without your written authorization to people who are preparing a future research project, so long as any information identifying you does not leave our facility. In the unfortunate event of your death, we may share your health information with people who are conducting research using the information of deceased persons, as long as they agree not to remove from our facility any information that identifies you.

**4. Completely De-identified or Partially De-identified Information.** We may use and disclose your health information if we have removed any information that has the potential to identify you so that the health information is "completely de-identified." We may also use and disclose "partially de-identified" health information about you if the person who will receive the information signs an agreement to protect the privacy of the information as required by federal and state law. Partially de-identified health information will *not* contain any information that would directly identify you (such as your name, street address, social security number, phone number, fax number, electronic mail address, website address, or license number).

**5. Incidental Disclosures.** While we will take reasonable steps to safeguard the privacy of your health information, certain disclosures of your health information may occur during or as an unavoidable result of our otherwise permissible uses or disclosures of your health information. For example, during the course of a treatment session, other patients in the treatment area may see, or overhear discussion of, your health information.

## **YOUR RIGHTS TO ACCESS AND CONTROL YOUR HEALTH INFORMATION**

*We want you to know that you have the following rights to access and control your health information.*

1. **Right To Inspect and Copy Records.** You have the right to inspect and obtain a copy of any of your health information that may be used to make decisions about you and your treatment for as long as we maintain this information in our records. This includes medical and billing records. To inspect or obtain a copy of your health information, please submit your request in writing to Melissa Odom, APRN at 2200 Winter Springs Blvd. #106-265, Oviedo, FL 32765. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies we use to fulfill your request. Under certain extremely limited circumstances, we may deny your request to inspect or obtain a copy of your information. If we do, we will provide a written denial that explains our reasons for doing so, and a complete description of your rights to have that decision reviewed and how you can exercise those rights.

2. **Right To Amend Records.** If you believe that the health information that we have about you is incorrect or incomplete, you may ask us to amend the information for as long as the information is kept in our records. To request an amendment, please write to Melissa Odom, APRN at 2200 Winter Springs Blvd. #106-265, Oviedo, FL 32765. Your request should include the reasons why you think we should make the amendment. If we deny all or part of your request, we will provide a written Notice that explains our reasons for doing so. You will have the right to have certain information related to your requested amendment included in your records.

3. **Right To an Accounting of Disclosures.** You have a right to request an “accounting of disclosures,” which identifies certain other persons or organizations to whom we have disclosed your health information in accordance with applicable law and the protections afforded in this Notice. Many routine disclosures we make will not be included in this accounting; however, the accounting will include many non-routine disclosures.

To request an accounting of disclosures, please write to Melissa Odom, APRN at 2200 Winter Springs Blvd. #106-265, Oviedo, FL 32765 and indicate a time period within the past six years for the disclosures you want us to include. You have a right to receive one accounting within every 12 month period for free. However, we may charge you for the cost of providing any additional accounting in that same 12 month period.

4. **Right To Request Additional Privacy Protections.** You have the right to request that we further restrict the way we use and disclose your health information to treat your condition, collect payment for that treatment, or run our business operations. You may also request that we limit how we disclose information about you to family or friends involved in your care. To request restrictions, please write to Melissa Odom, APRN at 2200 Winter Springs Blvd. #106-265, Oviedo, FL 32765. We are not required to agree to your request for a restriction, and in some cases the restriction you request may not be permitted under law. *However, if we do agree, we will be bound by our agreement unless the information is needed to provide you with emergency treatment or comply with the law.* Once we have agreed to a restriction, you have the right to revoke the restriction at any time. Under some circumstances, we will also have the right to

revoke the restriction as long as we notify you before doing so; in other cases, we will need your permission before we can revoke the restriction. You have the right to restrict certain disclosures of protected health information to a health plan where you pay, or someone on your behalf has paid for out of pocket and in full. You have the right to revoke the restriction at any time.

**5. Right To Request Confidential Communications.** You have the right to request that we contact you about your medical matters in a way that is more confidential for you, such as calling you at home instead of at work. To request more confidential communications, please write to Melissa Odom, APRN at 2200 Winter Springs Blvd. #106-265, Oviedo, FL 32765. *We will not ask you the reason for your request, and we will try to accommodate all reasonable requests.*

**6. Right To Have Someone Act On Your Behalf.** You have the right to name a personal representative who may act on your behalf to control the privacy of your health information. Parents and guardians will generally have the right to control the privacy of health information about minors unless the minors are permitted by law to act on their own behalf.

**7. Right To Obtain a Copy of Notices.** If this Notice is provided electronically, you have the right to a paper copy of this Notice, which you may request at any time. To do so, please call Melissa Wayne, APRN at 407-634-2104. You may also obtain a copy of this Notice by requesting a copy at your next visit. We may change our privacy practices from time to time. If we do, we will revise this Notice so you will have an accurate summary of our practices. We will post any revised Notice in our [waiting room/reception area]. You will also be able to obtain your own copy of the revised Notice. The effective date of the Notice will always be noted in the top right corner of the first page. We are required to abide by the terms of the Notice that is currently in effect.

**8. Right To File A Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, please contact: Melissa Odom, APRN at 2200 Winter Springs Blvd. #106-265, Oviedo, FL 32765.

*No one will retaliate or take action against you for filing a complaint.*

**9. Right To Be Notified Following a Breach of Unsecured PHI.** If you are affected by a breach of your unsecured protected health information, you have the right to, and will, receive notice of such breach.

**10. How To Learn About Special Protections For [HIV And Genetic Information].** Special privacy protections apply to [HIV test information, alcohol and substance abuse treatment information, mental health information, and genetic information]. Some parts of this general Notice of Privacy Practices may not apply to these types of information. For example, Florida law does not allow us to Fla. Stat. §

381.004(2)(e) provides that the identity of any person upon whom an HIV test has been performed is confidential and is exempt from disclosure under Florida’s Public Records laws. It also provides that any person who has obtained or knows a test result cannot disclose that result and they cannot be compelled to disclose the test result in a manner that identifies the person who took the HIV test except in very limited circumstances.

Fla. Stat. 381.004(2)(f) provides that whenever a disclosure is made concerning any HIV test of a patient that it contains a specific written statement that: “This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of such information without the specific written consent of the person to whom such information pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.”. If your treatment involves this information, you will be provided with separate Notices explaining how the information will be protected. To request copies of these other Notices, please contact Melissa Odom, APRN at 2200 Winter Springs Blvd. #106-265, Oviedo, FL 32765.

Please sign the “Acknowledge of Receipt of Notice of Privacy Practice” below. Failure to sign and submit does not constitute lack of knowledge of the THRIVE MEDICAL LLC HIPAA/Notice of Privacy Policy.

**ACKNOWLEDGMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES**

*By signing below, I acknowledge that I have been provided a copy of the Thrive Medical LLC HIPAA Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by Thrive Medical LLC and how I may obtain access to and control this information.*

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Print Name of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Personal Representative’s Authority