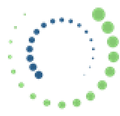


Tri-State Progressive Health

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.

Your use of Tri-State Progressive Health's services indicates your acceptance of the terms of this notice.

WHAT INFORMATION DO WE USE?

In order to provide our services, we collect information about you. Examples include demographic information, medical/surgical/psychiatric history and treatments, and billing needs such as credit card information. Most of this information is kept on paper in a locked cabinet in a locked office or on secure servers online. Some information is obtained or managed through third-parties such as your other health care providers, state-run controlled-substance databases, or payment management services.

OUR USES AND DISCLOSURES:

The following describes different ways that we use and disclose protected health information. For each use or disclosure, we will explain and provide an example. Not every use or disclosure in a category will be listed. The word "use" means to review, consult, read, update and study your protected health information so that we can provide health care to you in the best way that we can, and to perform other activities permitted or required by law. The word "disclose" means that we are providing your protected health information to someone outside of our practice so that individual may provide for you, understand your health condition or treatment received in order to explain it to you, or learn more about your particular health condition and treatment received.

We can use your health information to determine an appropriate treatment plan and share it with other medical professionals who are treating you. We may share and/or disclose protected health information with your primary care or mental health provider who prescribe medication for the condition we are treating

We can use and share your health information to run our practice, improve your care, and contact you when necessary. We may share and/or disclose protected health information about you to manage your treatment and services.

We can use and share your health information to bill for and obtain payment for our services. We may share and/or disclose protected health information with your insurance

company so it will pay for your services. If you are paying out of pocket in full, we will not need to share this information with your health insurer.

We may need to share your health information in the following situations:

- Public health and safety issues; reporting suspected abuse, neglect, or domestic violence; reporting suspected adverse reactions to medications
- Complying with any applicable federal, state, or local law
- In response to lawsuits and legal actions

We will NEVER share information about substance abuse history or HIV status without your written permission.

OUR RESPONSIBILITIES:

We are required by law to maintain the privacy and security of your protected health information.

We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

We must follow the duties and privacy practices described in this notice and give you a copy of it.

We will not use or share your protected health information other than as described here unless you tell us we can in writing. If you change your mind at any time, please let us know in writing.

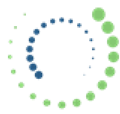
For more information, see https://www.hhs.gov/hipaa/for-individuals/notice-privacy-practices/index.html

YOUR RIGHTS:

You may request an electronic of paper copy of any or all of your medical record with Tri-State Progressive Health at any time. This request must be made in writing and will be honored within 14 days. The current fee for paper copies and mailing is $25.

You can ask for a paper copy of this privacy notice at any time, even if you have previously received an electronic or paper copy.

You have the right to inspect and copy your protected health information.



You can ask to amend your record if you feel it contains errors. This must be done in writing and state a reason for the proposed amendment. We are not obligated to amend the record if certain criteria are not met.

Only you have access to your personal medical information. If you would like someone else to have access to it, please indicate that here:

Name: ____ Relationship: ____________________________

Any authorizations provided may be revoked, in writing, by you at any time.

CHANGE OF NOTICE OF PRIVACY PRACTICES

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

Complaints:

If you believe your privacy rights have been violated, you may file a complaint with the practice and with the Secretary of the United States Health and Human Services for Civil Rights. To file a complaint with our office, please contact us at (606) 922-0695. You will not be penalized for filing a complaint.

Patient Signature: ____ Date: ________________________