

HIPAA Notice of Privacy Practices

FOX MEDICAL CENTER: 4620 Bridgeport Way W, Suite A, University Place WA 98466. 253-368-7822

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.

****PLEASE NOTE:** Fox Medical Center does not meet federal criteria for healthcare provider obligation for HIPAA compliance, however we believe that your privacy is critical to our relationship as your healthcare providers. We choose to follow the guidelines laid out below for your benefit. We do not anticipate changing this policy in the future and will not alter this policy without written notice and an opportunity for you to specifically request restrictions to release of your Personal Health Information.

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 operations (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, present, or future physical or mental health or condition and related health care services.

I. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information: Your PHI may be used and disclosed by your provider, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing medical services to you, to pay or confirm payment of your medical care bills from FMC, to support the operation of the provider's practice, and any other use required by law.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your PHI, as necessary, to a third party provider to whom you have been referred to ensure that the provider has the necessary information to diagnose or treat you.

Payment: Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for outside specialist services may require that your relevant PHI be disclosed to the health plan to obtain approval for said treatment.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your provider's practice. These activities may include, but are not limited to, quality assurance activities, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI, as necessary, to contact you to remind you of your appointment.

We may use or disclose your PHI in the following situations without your authorization. These situations include: as Required By Law, Public Health issues (as required by law), Abuse or Neglect, Legal Proceedings, Law Enforcement, Danger to Self or Others. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. Other permitted and required Uses and Disclosures will be made only with your consent, authorization, or opportunity to object unless

required by law. You may revoke this authorization at any time, in writing, except to the extent that your provider has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights - Following is a statement of your rights with respect to your PHI.

You have the right to inspect and copy your PHI. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI.

You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your provider is not required to agree to a restriction that you may request. If the therapist believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another Healthcare 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 upon request, even if you have agreed to accept this notice alternatively (i.e. electronically).

You have the right to have your provider amend your PHI. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such material.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.

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 in 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 August 2021. While we are not strictly required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to PHI, we do so as a convenience and for disclosure of our policies. If you have any objections to this form, please contact our office with specific objections at the contact information noted at the top of this form.

I acknowledge receipt of this HIPAA practices policy statement from Fox Medical Center.

Name _____ Date _____