

## **NOTICE OF PRIVACY PRACTICES**

*Effective Date: April 14, 2003  
Revised Date: January 20, 2009*

### **THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

#### **WHO WILL FOLLOW THIS NOTICE**

Family Practice Associates, Inc provides health care to our patients in a clinically integrated health care setting. The components of this setting include:

- All departments and units that are part of the health care operations of Family Practice Associates, Inc
- All employees, staff, students and other members of our medical staff and other licensed professionals treating you at any of our locations.

All these entities, persons and locations will follow the terms of this notice. In addition, each may share health information with the other for treatment, payment or hospital operations purposes as permitted by law.

#### **OUR PLEDGE TO YOU**

We understand that health information about you is personal. We are committed to protecting your health information. We create a record of the care and services you receive to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care that we maintain, whether generated by facility staff or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your health information created in the doctor's office.

The law requires us to:

- Maintain the privacy of our patient's health information;
- Provide you with this notice of our legal duties and privacy practices with respect to your health information; and
- Follow the terms of the notice that is currently in effect.

#### **HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU**

**Your Authorization:** Except as outlined below, we will not use or disclose your health information for any reason unless you have signed a form authorizing us to do so. You have the right to cancel your authorization in writing unless we have taken any action in reliance on the authorization.

**Uses and Disclosures for Treatment:** We will use and disclose your health information as needed for your treatment. For example, doctors and nurses and other professionals involved in your care will use information in your medical record, and/or information that you give them, in order to treat you. We may also disclose your health information to another health care facility or professional outside of Family Practice Associates, Inc who is or may be providing treatment to you. For instance, if after you leave the hospital you are going to receive home health care, we may release your health information to that home health care agency so that they can treat you.

**Uses and Disclosures for Payment:** We will use and disclose your health information for the purpose of allowing us, as well as other entities, to secure payment for the health care services provided to you. For example, we may forward information regarding your medical treatment to your health plan to arrange payment for the services given to you. We also may tell your health plan about a treatment you are going to receive in order to obtain prior approval or to determine whether your plan will cover the treatment.

**Uses and Disclosures for Health Care Operations:** We will use and disclose your health information as needed, and as permitted by law, in the process of our daily operations. For example, we may use and disclose your health information for purposes of improving the clinical treatment and care of our patients. We may also disclose your health information to another health care facility, health care professional or other entity for such things as quality assurance and case management, but only if they have or had a patient relationship with you.

**Family and Friends Involved In Your Care:** With your approval, we may disclose your health information to family, friends and others who are involved in your care or in payment of your care. If you are unable to give approval or facing an emergency, we may then share parts of your health information with them without your approval in order to treat you. We may also disclose limited health information to an entity that is authorized to assist in disaster relief efforts so your family can be notified of your condition, status and location.

**Business Associates:** Some of our health care operations such as auditing, accreditation, legal services, etc., may be performed through contracts with outside persons or organizations. At times, we may need to give some of your health information to these outside persons or organizations. In all cases, we require these persons or organizations to protect the privacy of your information.

**Appointments and Services:** We may contact you with reminders or test results. You may request that we provide this information by another means or at another location. For example, if you do not want appointment reminders left on voice mail or sent to a certain address, we will make every effort to accommodate reasonable requests. Please make this request in writing to the Privacy Officer listed at the end of this notice.

**Health Products and Services:** We may from time to time use your health information to communicate with you about health products and services necessary for your treatment, to advise you of new products and services we offer, and to provide general health and wellness information.

**Research:** In limited cases, we may use or disclose your health information for research. For example, a research organization may wish to compare all patients that received a certain drug and will thus need to review medical records. In all cases where your specific authorization has

not been obtained, your privacy will be protected by strict confidentiality requirements. These requirements are applied by an Institutional Review Board or privacy board, which oversees the research, or by representations of the researchers that limit their use and disclosure of patient information.

**Other Uses or Disclosures of Information:** We are permitted or required by law to make certain other uses and disclosures of your health information without your consent or authorization as follows:

- For any purpose required by law.
- For public health activities, such as required reporting of disease, injury, birth, death, and for public health investigations.
- If we suspect child abuse or neglect or if we think you are a victim of abuse, neglect, or domestic violence.
- To the Food and Drug Administration if necessary to report adverse events, product defects, or to participate in product recalls.
- To your employer when we have provided health care to you at the request of your employer to determine workplace-related illness or injury.
- To government agencies conducting audits, investigations, or civil or criminal proceedings.
- If required by subpoena or discovery request; in some cases you will have notice of such.
- To law enforcement officials as required by law or to report wounds or injuries and crimes.
- To coroners and/or funeral directors consistent with the law.
- If necessary to arrange an organ or tissue donation from you or a transplant for you;
- For certain research purposes when such research is approved by an institutional review board with established rules to ensure privacy;
- In limited instances, if we suspect a serious threat to health or safety.
- If you are a member of the military, as required by armed forces services; we may also release your health information if necessary for national security or intelligence activities.
- To workers' compensation agencies if necessary for your workers' compensation benefit determination.
- As required by Ohio law. Ohio law requires that we obtain a consent from you in many instances before disclosing the performance or results of an HIV test or diagnoses of AIDS or an AIDS-related condition; before disclosing information about drug or alcohol treatment you have received in a drug or alcohol treatment program; and before disclosing information about mental health services you may have received.

### **YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU**

**Right to Inspect and Copy:** You have the right to request a copy and/or inspect much of the health information that we keep on your behalf. All requests to inspect or copy must be made in writing and signed by you or your representative. If you request copies, you will be charged our regular fees for copying and mailing the requested information. You may obtain an access request form and a fee schedule from Family Practice Associates, Inc Medical Records.

**Right to Amend:** You have the right to request in writing that the health information we maintain about you be amended or corrected. We are not required to make all the changes/corrections you request; however we will give each request careful consideration. All

requests must be in writing, be signed by you or your representative and must state the reasons for the amendment/correction. If an amendment or correction you request is made by us, we may also notify others who work with us and have copies of the uncorrected record if we believe that such notification is necessary. You may obtain an amendment request form from Family Practice Associates, Inc Medical Records.

**Right to an Accounting of Disclosures:** You have the right to an accounting of certain disclosures we have made of your health information after April 14, 2003. Requests must be made in writing and signed by you or your representative. The first accounting in any 12-month period is free; you will be charged our regular fees for each subsequent accounting you request within the same 12-month period. You may obtain an accounting request form and a fee schedule from Family Practice Associates, Inc Medical Records.

**Right to Request Restrictions:** You have the right to request restrictions on certain uses and disclosures of your health information for treatment, payment or health care operations. We are not required to agree to your restriction request but will attempt to accommodate reasonable requests as appropriate, and we may terminate an agreed-to restriction if we believe such termination is appropriate. We will notify you if we terminate a requested restriction. You may also terminate, in writing or orally, any agreed-to restriction. You may obtain a restriction request form from Family Practice Associates, Inc Medical Records.

**Changes to This Notice:** We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all health information maintained by us. You may obtain a copy of any revised notices at the Family Practice Associates, Inc. Registration Desk or a copy may be obtained by mailing a request to the Privacy Office listed at the end of this notice.

**Complaints:** If you believe your privacy rights have been violated, you may file a complaint in writing or by phone with: Lisa Mark, CAPP 2300 Wales Ave NW, Massillon, OH, 44646. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. in writing within 180 days of a violation of your rights. There will be no retribution for filing a complaint.

**Acknowledgement of Receipt of Notice:** You will be asked to sign a form that you received this Notice of Privacy Practices.

**For Further Information about this Notice Contact:** Privacy Office, Family Practice Associates, Inc 2300 Wales Ave NW, Massillon, OH 44646.

You have the right to obtain a paper copy of this Notice upon request. Paper copies may be obtained from the Family Practice Associates, Inc Registration Desk or from the Privacy Office listed above.