West Little Rock Women's Center

Notice of Privacy Practices for Protected Health Information

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!

If you consent, the office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. *Protected health information* is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care of treatment. It also includes billing documents for those services.

Examples of uses of your health information for treatment purposes are:

- A nurse obtains treatment information about you and records it in a health record.
- During the course of your treatment, the physician determines he/she will need to consult with another specialist in the area. He/she will share the information with such specialist and obtain his/her input.

Example of use of your health information for payment purposes:

- We submit requests for payment to your health insurance company. The health insurance company or business associate helping us obtain payment requests information from us regarding your medical care given. We will provide information to them about you and the care given.

Example of Use of Your Information for Health Care Operations:

We may obtain services from business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services and insurance. We will share information about you with such business associates as necessary to obtain these services.

We may use and disclose your medical information to contact you in regards to upcoming appointments for treatment or medical care at our office.

Your Health Information Rights

The health and billing records we maintain are the physical property of the doctor's office. You have the following rights with respect to your protected health information:

1. Right to request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted.

2. Right to obtain a paper copy of the Notice of Privacy Practices for Protected Health Information ("Notice") by making a request at our office.

3. Right to inspect and copy your health record and billing record. You may exercise this right by delivering the request in writing to our office using the form we provide to you upon request as well as appeal a denial of access to your protected health information, except in certain circumstances.

4. Right to request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office using the form we provide to you upon request. The physician or other health care provider is not required to make such amendments, but you may file a statement of disagreement if your amendment is denied. You may also require that the request for amendment and any denial be attached in all future disclosures of your protected health information.

5. Right to receive an accounting of disclosures of your health information, as required to be maintained by law, by delivering a written request to our office using the form we provide to you upon request. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care.

6. Right to confidential communication by requesting that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office using the form we give you upon request.

7. Right to receive notice of a breach. We are required to notify you by first class mail of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days following the discovery of the breach. "Unsecured Protected Health Information" is information that is not secured through the use of a technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services (HHS) to render the Protected Health Information unusable, unreadable, and undecipherable to unauthorized users. The notice is required to include the following information:

    a. A brief description of the breach, including the date of the breach and the date of its discovery, if known;
    b. A description of the type of Unsecured Protected Health Information involved in the breach;
    c. Steps you should take to protect yourself from potential harm resulting from the breach;
    d. A brief description of actions we are taking to investigate the breach, mitigate losses, and protect against further breaches;
    e. Contact information, including a toll-free telephone number, email address, web site, or postal address to permit you to ask questions or obtain additional information.

In the event the breach involves 10 or more patients whose contact information is out of date, we will post a notice of the breach on the home page of our website or in a major print or broadcast media. If the breach involves more than 500 patients in the state or jurisdiction, we are required to immediately notify the Secretary of HHS. We also are required to submit an annual report to the Secretary of a breach that involved less than 500 patients during the year and will maintain a written log of breaches involving less than 500 patients.

If you want to exercise any of the above rights, please contact the Office Manager, in person or in writing, during normal hours. She will provide you with assistance on the steps to take to exercise your rights.

You have the right to review this Notice before signing the consent authorizing use and disclosure of your protected health information for treatment, payment, and health care operations purposes.

Our Responsibilities

The office is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice of our duties and privacy practices regarding the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request;
- Accommodate your reasonable request regarding methods to communicate health information to you; and,
- Accommodate your request for an accounting of disclosures.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices, and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact our **Office Manager** at **(501) 907-6699.** Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to the Office Manager. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services.

We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office.

We cannot and will not retaliate against you for filing a complaint with the Secretary of HHS.

Following is a List of Other Uses and Disclosures Allowed by the Privacy Rule

Patient Contact

We may contact you to provide you with appointment reminders, with information about treatment alternatives, or with information about other health-related benefits and services that may be of interest to you.

Notification – Opportunity to Agree or Object

Unless you object, we may use or disclose your protected health information to notify or assist in notifying a family member, personal representative, or other person responsible for your care in regards to your location, your general condition, or your death.

Communication with Family

Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object, or in an emergency.

We may use and disclose your protected health information to assist in disaster relief efforts, but in such an event, we are not required by law to offer an opportunity to agree or object.

PUBLIC HEALTH ACTIVITIES

Controlling Disease – As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Child Abuse & Neglect - We may disclose protected health information to public authorities, as allowed by law, to report child abuse or neglect.

Food and Drug Administration (FDA) – We may disclose to the FDA your protected health information relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

VICTIMS OF ABUSE, NEGLECT, OR DOMESTIC VIOLENCE

We can disclose protected health information to governmental authorities to the extent the disclosure is authorized by statute or regulation and also when, in the exercise of professional judgment, the doctor believes the disclosure is necessary to prevent serious harm to the individual or other potential victim.

OVERSIGHT AGENCIES

Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities to include audits, civil, administrative or criminal investigations: inspections; licensures or disciplinary actions, and for similar reasons related to the administration of healthcare.

JUDICIAL/ADMINISTRATIVE PROCEEDINGS

We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order or administrative tribunal, provided that the protected health information released is expressly authorized by such order, or in response to a subpoena, discovery request, or other lawful process.

LAW ENFORCEMENT

We may disclose your protected health information for law enforcement purposes as required by law, such as when required by court order, including laws that require reporting of certain types of wounds or other physical injury.

CORONERS, MEDICAL EXAMINERS AND FUNERAL DIRECTORS

We may disclose your protected health information to funeral directors, medical examiners, or coroners consistent with applicable laws to allow them to carry out their duties.

ORGAN PROCUREMENT ORGANIZATIONS

Consistent with applicable laws, we may disclose your protected health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs, eyes, or tissue for the purpose of donation and transplant.

THREAT TO HEALTH AND SAFETY

To avert a serious threat to health or safety, we may disclose your protected health information consistent with applicable laws to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.

FOR SPECIALIZED GOVERNMENTAL FUNCTIONS

We may disclose your protected health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to the public assistance program personnel.

CORRECTIONAL INSTITUTIONS

If you are an inmate of a correctional institution, we may disclose to the institution or its agents the protected health information necessary for your health and the health and safety of other individuals.

WORKERS COMPENSATION

If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

OTHER USES AND DISCLOSURES

- **Organized Healthcare Arrangement -** Our office, the independent contractor members of its medical staff (including your physician), and other healthcare providers affiliated with our office have agreed, as permitted by law, to share your health information among themselves for purposes of treatment, payment or health care operations. This enables us to better address your healthcare needs.
- Other uses and disclosures besides those identified in the Notice will be made only as otherwise authorized by law or with your written authorization which you may revoke except to the extent information or action has already been taken.

Website

- We maintain a website that provides information about our entity (www.wlrwomens.com) and this Notice will be available on that website.

Revision Date: ***February 3, 2015***, to be compliant with HIPAA Omnibus Privacy Rules.

Original Effective Date: ***July 1, 2011***

West Little Rock Women's Center
12921 Cantrell Rd. Suite 300 Little Rock, AR 72223
501-907-6699

ACKNOWLEDGEMENT OF RECEIPT OF *NOTICE OF PRIVACY PRACTICES*

I acknowledge that I have been provided with West Little Rock Women's Center's *Notice of Privacy Practices* ("*Notice*"):

- The *Notice* informs me how the clinic will use my protected health information for the purposes of treatment, payment, and the clinic's health care operations.
- The *Notice* explains under what conditions the clinic may use and share my protected health care information for purposes other than treatment, payment, and health care operations.
- The *Notice* affirms that the clinic will use and share my protected health information as required and permitted by law.

I consent to the clinic's use and disclosure of my protected health information as detailed in the clinic's *Notice of Privacy Practices.*

Patient's Full Name: _____
(Please print)

Patient's DOB: _____ Date: _____

Signature: _____
(Patient or Legal Representative)

PATIENT REGISTRATION

PATIENT INFORMATION

(Please Print)
Patient Name_____ Date_____
(Last) (First) (Middle)

Address_____ Birthdate_____Age___ M( ) F( )
(Street, Highway or P.O. Box)
Single( ) Married( )
_____ Divorced( ) Widow( ) Separated( )
(City, State, Zip)

Race _____ Ethnicity: ( ) Hispanic ( ) Non-Hispanic

Home Phone _____ Cell Phone _____ Patient SSN _____

Patient Employer _____ Occupation _____ Spouse Name _____

Address _____ Work Phone _____

REFERRAL INFORMATION

Ref Physician_____ Primary Phys_____

Ref Friend_____

Have you or any family member ever been a patient here? Yes( ) No( ) Name_____Relationship _____

Name and relationship of closest relative (other than spouse):_____ Relationship_____

Emergency Contact_____ Phone Number: _____

INSURANCE INFORMATION

Primary Carrier	Secondary Carrier
Address to Send Claim to	Address to Send Claim to
_____	_____
Phone	Phone
ID/Policy#_____ Group#_____	ID/Policy#_____ Group#_____
Policy Holder's Name	Policy Holder's Name
Policy Holder's SSN	Policy Holder's SSN
Policy Holder's Date of Birth	Policy Holder's Date of Birth

CONSENT AUTHORIZATION

I hereby authorize West Little Rock Women's Center to render medical services and I request that payment of authorized benefits be made either to me or on my behalf to West Little Rock Women's Center for any services furnished me by West Little Rock Women's Center. I authorize any holder of medical information about me to release to the health care financing administration and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____
Signature of Patient or Authorized Representative Date