

**TABLE OF CONTENTS
NOTICE OF PRIVACY ACT**

A. OUR COMMITMENT TO YOUR PRIVACY 2

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:..... 2

**C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH
INFORMATION (IIHI) IN THE FOLLOWING WAYS 2**

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES 3

E. YOUR RIGHTS REGARDING YOUR IIHI 5

END 7

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES 7

INTENTIONALLY LEFT BLANK

Notice of Privacy Practices

As required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI).

PLEASE REVIEW THIS NOTICE CAREFULLY

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicate, but we must provide you with the following important information:

- How we may use and disclose your IIHI.
- Your privacy rights in your IIHI.
- Our obligations concerning the use and disclosure of your IIHI.

The terms of this notice apply to all records containing your IIHI that are retained by our practice. We reserve the right to amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of our records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Kristina Walker– Phone No.: (678) 833-1444

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY INDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI:

1. **Treatment.** Our practice may use your IIHI to treat you and we may use the results to help us reach a diagnosis. We might use your IIHI to order a prescription for you. Many of the peossple who work for our practice, including, but not limited to, our doctors and nurses – may use or disclose your IIHI in order to treat you or assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children, or parents.
2. **Payment.** Our practice may use and disclose your IIHI to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer, with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for serves and items.
3. **Health Care Operations.** Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information of our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice.
4. **Appointment Reminders.** Our practice may use and disclose your IIHI to contact you and remind you of an appointment.
5. **Treatment Options.** Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.
6. **Health-Related Benefits and Services.** Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.
7. **Release of Information to Family/Friends.** Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a baby-sitter take their child to the pediatrician’s office for treatment of a cold. In this example, the baby-sitter may have access to this child’s medical information.
8. **Disclosures Required by Law.** Our practice will use and disclose your IIHI when we are required to do so by federal, state, or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

1. **Public Health Risks.** Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births or deaths.
- Reporting child abuse or neglect.
- Preventing or controlling disease, injury or disability
- Notifying a person regarding exposure to a communicable disease or condition.

- Reporting reactions to drugs or problems with products or devices.
 - Notifying individuals if a product or device they may be using has been recalled.
 - Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information.
 - Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.
- 2. Health Oversight Activities.** Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure, and disciplinary actions; civil, administrative and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
- 3. Lawsuits and Similar Proceedings.** Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have an effort to inform you of your request or to obtain an order protecting the information the party has requested.
- 4. Law Enforcement.** We may release IIHI if asked to do so by a law enforcement official:
- Regarding a crime victim in certain situations, if we are unable to obtain the person’s agreement.
 - Concerning a death we believe has resulted from criminal conduct.
 - Regarding criminal conduct at our offices.
 - In response to a warrant, summons, court order, subpoena or similar legal process.
 - To identify/locate a suspect, material witness, fugitive or missing person.
 - In an emergency, to report as crime (including the locations or victim(s) of the crime, or the description, identity or locations of the perpetrator).
- 5. Deceased Patients.** Our practice may release your IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.
- 6. Organ and Tissue Donation.** Our practice may release your IIHI to organizations that handle organ, eye, or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.
- 7. Research.** Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research except when: (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the oral or written agreement of a researcher that (i) the information being sought is necessary

for the research study; (ii) the use or disclosure of your IIHI is being used only for the research; (iii) the researcher will not remove any of your IIHI from our practice; or (c) the IIHI sought by the researcher agrees either orally or in writing that the use or disclosure is necessary for the research and, if we request it, to provide us with proof of death prior to access to the IIHI of the decedents.

- 8. Serious Threats to Health or Safety.** Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
- 9. Military.** Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
- 10. National Security.** Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.
- 11. Inmates.** Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary; (a) for the institutions to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.
- 12. Workers Compensation.** Our practice may release your IIHI for worker's compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

- 1. Confidential Communications.** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **Kristina Walker** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.
- 2. Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment of your care, such as family members and friends. **We are not required to agree to your request**, however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our

use or disclosure of your IIHI, you must make your request in writing to **Kristina Walker**. Your request must describe in a clear and concise fashion:

- (a) information you wish restricted;
- (b) whether you are requesting to limit our practice's use, disclosure, or both; and
- (c) to whom you want the limits to apply.

- 3. Inspection and Copies.** You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **Kristina Walker** in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.
- 4. Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to **Kristina Walker**. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not available to amend the information.
- 5. Accounting of Disclosures.** All of our patients have the right to request "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment or operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor shares information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to **Kristina Walker**. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April, 14, 2003. The first list you request within a 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.
- 6. Right to Paper Copy of This Notice.** You are entitled to receive a copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact **Kristina Walker**.
- 7. Right to File Complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services or the OCR in Georgia at (404) 347-3125. To file a complaint with our practice, contact **Kristina Walker**. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note; we are required to retain records for your care.

END

(Please detach at dotted line. Fill out bottom portion and give to office personnel)



As required by the Privacy Regulations Created as a result of the
Health Insurance Portability and Accountability Act of 1996 (HIPAA)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of **TRUFFLES VEIN CENTER, LLC, Notice of Privacy Practices.**

Signature of Patient/Legal Representative

Date

HIPAA CONSENT

CONSENT TO LEAVE MESSAGE

Patient Name: _____
(Print)

Date: _____

I wish to be called at home ; other (check all that apply) regarding my care, follow-up, and financial information. The best telephone number(s) to reach me are:

_____ Home _____ Other

I do give permission to leave relevant medical and/ or financial information on my answering machine or voicemail.

I do **NOT** give permission to leave relevant medical and/ or information on my answering machine or voicemail.

The name(s) of the individual(s) with whom you may leave pertinent information are:

Patient Signature

Date