

**CULLMAN DERMATOLOGY CLINIC, P.C.**

**HIPAA 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.**

**CULLMAN DERMATOLOGY CLINIC, P.C., (“PC”)** is required to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to your protected health information. We will not use, release or disclose your health information except as described in this Notice of Privacy Practices (“Privacy Notice” or “Notice”), unless specifically authorized by you in writing. We are also required by law to notify you following a breach of unsecured protected health information. In providing professional medical services to you, we will create, maintain, and store your protected health information.

**WHAT HEALTH INFORMATION IS PROTECTED**

We are committed to protecting the privacy of health information we gather about you while providing health-related services. Some examples of protected health information are information about your health condition; information about health care services you have received or may receive in the future; information about your health care benefits under an insurance plan; geographic information; demographic information; unique numbers that may identify you; and other types of information that may identify who you are.

**EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH OPERATIONS:** The following categories describe the ways that we may use, release, and disclose your health information for treatment, payment, and health care operations **without the need** for a signed authorization from you.

**Treatment:** We will use your protected health information in the provision and coordination of your health care. For example, we may disclose all or any portion of your medical record information as part of your care and continued treatment to your attending physician and other health care providers who have a legitimate need for such information.

**Family/Friends:** The PC may release protected health information about you to a friend or family member *who is involved* in your medical care. We may also give information to someone who helps pay for your care, and we may also tell your family or friends of your condition and that you are at the PC. We will give you an opportunity to agree or object to these disclosures.

**Payment:** The PC may release protected health information about you for the purposes of determining coverage, billing, claims management, medical data processing, and reimbursement. For example, the information may be released to an insurance company, third party payor or other entity (or their authorized representatives) involved in the payment of your medical bill and may include copies of your medical record needed to pay your account.

**Healthcare Operations:** The PC may use and disclose your protected health information during routine healthcare operations. These operations may include quality assurance, utilization review, medical review, internal auditing, accreditation, certification, licensing or credentialing activities, management and administration of the PC, and educational purposes.

**Appointment Reminders:** The PC may use and disclose protected health information to contact you as a reminder that you have an appointment for treatment, medical care or follow-up at the PC and may leave a message for you at the number that PC has listed for you.

The Practice may also use and disclose your protected health information without your authorization for the following purposes:

**Health Related Business, Services and Treatment Alternatives** - Your medical information may be used or disclosed to tell you of health-related benefits or services provided by the PC that may be of interest to you and your particular medical condition.

**Alternatives** - Your medical information may be used or disclosed to tell you of health-related benefits or services provided by the PC that may be of interest to you and your particular medical condition.

**Regulatory Agencies** - Your medical information may be disclosed to a health oversight agency for activities authorized by law including, but not limited to, licensure, certification, audits, investigations and inspections.

**Law Enforcement/Litigation** - Your medical information may be disclosed to a law enforcement official for law enforcement purposes as required by law or in response to a valid subpoena or court order.

**Public Health** - Your medical information may be disclosed to public health or legal authorities charged with preventing or controlling disease, injury or disability.

**Serious Threat to Health or Safety** - Your medical information may be used or disclosed to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public.

**Military/Veterans/National Security** - Your medical information may be disclosed, as required by military command authorities, if you are a member of the armed forces. In addition, the PC may disclose your medical information to federal officials for intelligence and national security activities authorized by law.

**Required by Law** - Your medical information may be used or disclosed when required to do so by law.

**Coroners, Medical Examiners, Funeral Directors** - Your medical information may be disclosed to a coroner, medical examiner, or to funeral directors as necessary to carry out their duties.

**Research** - Your medical information may be used or disclosed for research purposes in certain limited circumstances.

**Workers Compensation** - Your medical information may be used or disclosed to release medical information about you for workers' compensation or similar programs as required under Alabama law.

#### **YOUR AUTHORIZATION IS NEEDED FOR OTHER USES AND DISCLOSURES**

We will not use or disclose your health information for any other purpose not described in this Notice unless you give us written authorization to do so. A signed authorization is necessary for most uses and disclosures related to psychotherapy notes (where appropriate). Uses and disclosures of protected health information for marketing purposes and disclosures that constitute a sale of protected health information also require an authorization. If you give us written authorization to use or disclose your health information for a purpose that is not described in this Notice, then you may revoke it in writing at any time. Your revocation will be effective for all your health information that we maintain, unless we have taken action in reliance on your authorization. We may engage in promotional activities from time to time. You have the right to opt out of receiving any communications from us regarding promotions.

## YOUR INDIVIDUAL RIGHTS

You have the following rights concerning your medical information. Please note that to exercise any of the privacy rights described below, you **must** complete a written request and send it to the PC's Privacy Officer at **CULLMAN DERMATOLOGY CLINIC, P.C.** at 1205 County Road 1466, Cullman, Alabama 35058. **You have the right to:**

1. Request that the PC communicate with you about your health and related issues in a particular manner or at certain locations;
2. Inspect and copy your health record as provided by the HIPAA Privacy Rule in 45 C.F.R. § 164.524;
3. Obtain an accounting of the use or disclosure of your health information as provided in 45 C.F.R. § 164.528;
4. Request restrictions on certain uses and disclosures of your medical information. The PC may not agree to honor your request for restrictions. We are not required to agree to your request for a restriction, and in some cases the restriction you request may not be permitted under law. *If we do agree to your request to restrict the use and disclosure of health information, we will be bound by our agreement unless the information is needed to provide you with emergency treatment or comply with the law.* Please note that we must agree to your request to restrict disclosure of your health information to a health plan if (a) the request is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and (b) the information pertains solely to a health care item or service for which you have already paid us in full.
5. Receive a paper copy of this Privacy Notice, upon request;
6. Revoke any authorization allowing the PC to use or disclose your medical information except to the extent that action has already been taken by the PC; and
7. Amend your health record as provided in 45 C.F.R. § 164.526.

**FOR MORE INFORMATION OR TO REPORT A PROBLEM:** If you have questions and would like additional information or if you believe your privacy rights have been violated, please contact our Privacy Officer. All complaints must be submitted in writing. There will be no retaliation for filing a complaint or expressing a concern. You may also file a complaint with to the Region IV, Office of Civil Rights, Department of Health and Human Services, Sam Nunn Atlanta Federal Center, Suite 16T70, 61 Forsyth Street, SW., Atlanta, GA 30303-8909. Voice Phone 800-368-1019, Fax 404-562-7881, TDD 800-537-7697 or via <http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html>.

**CHANGES TO THIS NOTICE:** The PC reserves the right to change the terms of its Privacy Notice and to make the new Notice provisions effective for all individually identifiable health information that it maintains.

**EFFECTIVE DATE:** The effective date of the Privacy Notice is **April 2014.**