



## 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.**

This serves as our Health Information Portability and Accountability Act (HIPAA) notice. It took effect on January 20, 2015, and remains in effect until we replace it.

#### **1. OUR PLEDGE REGARDING MEDICAL INFORMATION**

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

#### **2. OUR LEGAL DUTY**

##### **Law Requires Us to:**

- Keep your medical information private.
- Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
- Follow the terms of the current notice.

##### **We Have the Right to:**

- Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
- Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

##### **Notice of Change to Privacy Practices:**

- Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

#### **3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION**

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

**FOR TREATMENT:** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you with your other health care providers to assist them in treating you.

**FOR PAYMENT:** We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

**FOR DATA BREACH NOTIFICATION PURPOSES:** We may use your medical information to provide legally required notices of unauthorized acquisition, access, or disclosure of your health information due to a breach.

**FOR HEALTH CARE OPERATIONS:** We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to service you.

**ADDITIONAL USES AND DISCLOSURES:** In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

**Notification:** We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of an emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information to you.

**Disaster Relief:** We may share medical information with a public or private organization or person who can legally assist in a disaster relief efforts.

**Research in Limited Circumstances:** We may use your medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information or where we are improving our services.

**Funeral Director Coroner, Medical Examiner:** To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

**Specialized Government Functions:** Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

**Court Orders and Judicial and Administrative Proceedings:** We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful processes, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

**Public Health Activities:** As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

**Victims of Abuse, Neglect, or Domestic Violence:** We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

**Workers' Compensation:** We may disclose health information when authorized or necessary to comply with laws relating to workers' compensation or other similar programs.

**Health Oversight Activities:** We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

**Law Enforcement:** Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

**Appointment Reminders:** We may use and disclose medical information for purposes of sending you appointment emails, phone calls, texts, postcards, or otherwise reminding you of your appointments.

**Alternative and Additional Medical Services:** We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. If you request copies, we will charge you \$5 plus postage if you want the copies mailed to you. Additionally, if we maintain an electronic health record containing your health information, you have the right to request that we send a copy of your health information in an electronic format to you or to a third party that you identify. We may charge a reasonable fee for sending the electronic copy of your health information.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency)
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the contact person listed at the end of this notice.
7. You have the right to restrict information given to your third-party payer (e.g. health insurance plan) if you full paid for your health care services out of your own pocket. If you paid in full for services out of your own pocket, you can request that the information regarding the services not be disclosed to your third-party payer since no claim is being made against the first party payer.
8. You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information. Notice of any such breach will be made in accordance with federal regulations.

#### **QUESTIONS AND COMPLAINTS:**

If you have any questions about this notice, or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. You may contact us to submit a complaint or submit requests involving any of your rights in Sections 4 of this notice by writing to the following address:

---



---

## PATIENT INFORMATION

### HIPPA-ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**Patient's Full Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

Costus Medical is required by law to maintain privacy and provide individuals with the attached notice of our legal duties and privacy practices with respect to Protected Health Information. If you have any objections to this notice, please ask to speak with our HIPAA Compliance Officer. If you would like a copy of the notice, one will be provided for you.

**I hereby acknowledge that I have received and reviewed the HIPAA Notice of Privacy Practice document.**

\_\_\_\_\_  
**Patient or Patient's Representative Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print Name of Patient**

\_\_\_\_\_  
**Print Name of Patient's Representative**

\_\_\_\_\_  
**Relationship to Patient**



# PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for \_\_\_\_\_ to use and disclose Protected Health Information (PHI) about me to carry out Treatment, Payment, and Health Care Operations (TPO).

I have the right and have had the opportunity to review the Notice of Privacy Practices prior to signing this consent, should I choose to revoke my authorization. Costus Medical has reserved the right to revise its Notice of Privacy Practices at any time. I understand that I may obtain a revised Notice of Privacy Practices by written request to Costus Medical. I consent to allow participation/observation of my treatment to persons who may be present for purposes of education/training concerning the treatment or who are present to advise concerning improvements to treatment or research about the treatment. I understand that \_\_\_\_\_ will maintain a record of those present and that a copy will be made available to me upon request.

With this consent, \_\_\_\_\_ may call or text me at my home or other alternative location and leave a message in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, or other items pertaining to my clinical care, such as laboratory test results; and that \_\_\_\_\_ may send to my home or other alternative location any items that assist in carrying out TPO, such as appointment reminder cards and patient statements, as long as they are marked "Personal and Confidential."

I have the right to request that \_\_\_\_\_ restrict how it uses or discloses my PHI to carry out TPO. **Costus Medical** is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I understand that I am signing this authorization voluntarily and that TPO for my benefits will not be affected if I do not sign it. I further understand that I have the right to receive a copy of this authorization.

By signing this form, I have read the HIPAA Disclosure, and I am consenting to allow \_\_\_\_\_ to use and disclose my PHI to carry out TPO.

\_\_\_\_\_  
**Patient or Patient's Representative Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Print Name of Patient**

\_\_\_\_\_  
**Print Name of Patient's Representative**

\_\_\_\_\_  
**Relationship to Patient**