

# NOTICE OF PRIVACY PRACTICES

## Family Practice Medical Center of Willmar

### 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

If you have any questions about this notice, please contact Stacey Zondervan, Patient Services Director at (320) 231-8625.

#### OUR PLEDGE REGARDING HEALTH INFORMATION:

We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this health care practice, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

#### We are required by law to:

- make sure that health information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to health information about you; and
- follow the terms of the notice that is currently in effect.

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

The following categories describe different ways that we use and disclose health information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

**Treatment** means disclosing your personal health information to doctors, nurses, technicians, health students, or other personnel who are involved in taking care of you. For example, we may disclose your information to another health care provider to order a referral, to fill a prescription or for treatment purposes.

**Payment** means disclosing your personal health information to obtain reimbursement for services, confirming coverage, and billing or collection activities. For example, in order to bill an insurance company, we will have to disclose information about when you were treated, the conditions you were treated for, and the type of treatment you received.

**Health Care Operations** includes the business aspects of running our practice such as conducting quality assessment and improvement activities, auditing functions and customer service.

**Required By Law** includes requirements allowed for federal, state, or local law.

**To Avert a Serious Threat to Health or Safety** includes releasing your personal health information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

**Military and Veterans.** If you are a member of the armed forces or separated/discharged from military services, we may release health information about you as required by military command authorities or the Department of Veterans Affairs.

**Workers' Compensation** includes releasing your personal health information for work-related injuries or illness.

**Public Health Risks** includes Public Health concerns such as: prevention or disease control, notifying persons who may have been exposed to a disease or may be at risk for contracting or spreading a disease.

**Health Oversight Activities** includes agencies authorized by law that conduct audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Special Situations** including:

- **Legal Proceedings:** We may disclose health information about you in response to a court or administrative order, a subpoena, a discovery request, or other lawful process.
- **Law Enforcement:** We may disclose health information to comply with laws that require the reporting of certain types of injuries, to locate a criminal suspect, or to provide information about the victim of a crime.
- **Coroners, Health Examiners and Funeral Directors:** We may release health information to a coroner or health examiner or funeral director to allow them to perform their duties.

**National Security and Intelligence Activities** includes releasing personal health information about you to authorized federal officials for national security activities authorized by law.

**Inmates.** We may release health information about you to the correctional institution or law enforcement official to allow the institution to (1) provide you with health care; (2) protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

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

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

- **The right to inspect and copy your protected health information.** We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be Reviewed. Another licensed health care professional chosen by our practice will review your request and the denial. We will comply with the outcome of the review.
- **The right to request restrictions on certain uses and disclosures of protected health information.** Including those related to disclosures to family members, relatives, or any other person identified by you. We are however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it. In your request, you must tell us what information you want to limit and to whom you want the limits to apply.
- **The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.**
- **The right to amend your protected health information.** In addition, you must provide a reason that supports your request for an amendment. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (1) was not created by us; (2) is not part of the health information kept by or for our practice; (3) is accurate and complete.
- **The right to receive an accounting of disclosures of protected health information.**
- **The right to obtain a paper copy of this notice from us upon request.**

### **CHANGES TO THIS NOTICE**

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain the effective date. In addition, each time you register for treatment or health care services, we will offer you a copy of the current notice in effect.

### **COMPLAINTS**

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact Stacey Zondervan, Patient Services Director. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

### **OTHER USES OF HEALTH INFORMATION**

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

### **Acknowledgement of Receipt of this Notice**

We will request that you sign a separate form or notice acknowledging you have received a copy of this notice. If you choose, or are not able to sign, a staff member will sign their name, date. This acknowledgement will be filed with your records.

**Acknowledgement of Receipt of Notice of Privacy Practices**

I, \_\_\_\_\_, have received the Notice of Privacy Practices from Family Practice Medical Center of Willmar.

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

In lieu of patient signature, I, \_\_\_\_\_, a staff member of Family Practice Medical Center of Willmar, state that \_\_\_\_\_ has been given our current Notice of Privacy Practices.

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