

**URBAN FAMILY PRACTICE ASSOCIATES, PC  
NOTICE OF PRIVACY PRACTICES**

This notice describes how your identifiable medical information (called protected health information or PHI) may be used or disclosed, and to notify you of your rights regarding this information, and how you can obtain access to this information.

**PLEASE REVIEW CAREFULLY.**

This notice describes our practice's procedures and that of:

- Any health care professional authorized to enter information into your medical records
- All departments and units of our practice
- Any member of a volunteer group we allow to help you while you are in our practice
- All employees, staff and other practice personnel

**OUR PLEDGE REGARDING YOUR HEALTH INFORMATION**

We understand that information about you and your health is personal. We are committed to protecting your health information; (PHI) Protected Health Information. We create a record of the care and services you receive at our practice, as well as records regarding payment for those services. This notice applies to all the records of your care generated by our practice; physicians, and/or personnel working for the practice.

This notice will explain the ways in which we may use and may disclose medical information about you. We also describe your rights, and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- Make sure medical information that identifies you is kept private
- Give you this notice of our legal duties and privacy practices with respect to medical information about you
- Follow the terms of the notice that is currently in effect

**WHAT IS "PROTECTED HEALTH INFORMATION" (PHI)?**

Protected Health Information (PHI) is information about your age, race, sex and other personal health information that may identify you. The information may relate to your physical or mental health in the past, present, or future, and to the care, treatment, and services needed by you because of your health.

**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 and give examples. Not every use of disclosure will be listed. However, all of the ways we are permitted to use and disclose information will fall in one of the categories.

**TREATMENT:** We may use health 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 personnel who are involved in taking care of you. For instance, we may need to share information about your condition with another doctor if you have complications or need to see a specialist. Our practice may share

medical information about you in order to coordinate the different things you need, such as prescriptions and lab work.

**PAYMENT:** We may use and disclose health information about you so that the treatment and services you receive at our practice may be billed, and that payment may be collected from you, your insurance company or a third party. For example, we may need to give your health plan information about services that you received at our practice in order for your health plan will pay use or reimburse you for the services. We may also tell your health plan about a treatment you are going to receive in order to obtain prior approval or to determine whether your plan will cover the treatment.

**FOR HEALTH CARE OPERATIONS:** We may use and disclose health information about you for the practices' health care operations. These uses, and disclosures are necessary to run our office and to make sure all patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many of our patients to decide what additional services our practice should offer, what services are needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, residents, and other office personnel for review and training purposes. We may also disclose your information in conducting or arranging other business activities of the practice. We may disclose information as part of a sale, transfer, merger or consolidation of our office to another entity covered by the privacy rule. We may also combine the medical information we have with medical information from other facilities to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information, so others may use it to study healthcare delivery without learning who the specific patients are.

**APPOINTMENT REMINDERS:** We may disclose information, if necessary, to contact you to remind you about your appointments, by phone, email, or text messages.

**TREATMENT ALTERNATIVES:** We may use and disclose medical information to tell you about recommended possible treatment options or alternatives that may be of interest to you.

**HEALTH-RELATED BENEFITS AND SERVICES:** We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

**INDIVIDUALS INVOLVED IN YOUR CARE OF PAYMENT PLAN:** We understand that family and friends are an integral part of a patients care. If you wish to authorize a family member or friend to receive or request information regarding your care or test results, please provide their name and contact information when completing the PSFM – Permission to Speak with Family Member. We will not release your information to any family member or friend without your written consent. If you wish to change or update the authorized individuals, you will need to make these updates in writing.

In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be informed about your condition and location.

**HIE – HEALTH INFORMATION EXCHANGE:** Your information may be shared with other healthcare providers via the Health Information Exchange (HIE). Our office is currently participating in the Emory HIE. The function of the HIE is to improve patient-centered healthcare through the use and exchange of electronic health information. This collaborative effort seeks to close the patient information gap by allowing authorized healthcare providers to share their patients' records on an as-needed basis to support improved quality of care and patient health outcomes, as well as to potentially reduce patient healthcare costs.

- Types of Data Exchanged – Members of the HIE share electronic health records, which may include your medical history, allergies, radiology, labs, doctors' notes and/or immunizations. Sensitive information that requires specific written authorization to disclose will not be shared through HIE;

this includes mental health and psychotherapy records. In the event you want this this type of information shared, an express written consent will be required for each release. However, sensitive health information, including, but not limited to; substance abuse records, HIV/AIDS information, genetic testing, and developmental disability records may be viewed through the HIE unless you opt-out of the HIE.

- Permitted Disclosure – The HIE ensures protection of patients’ personal information by limiting use of patient health data to ensure meaningful use. We use information about you for treatment, analyzing procedures and lab results. We also use PHI to obtain payment for health care operations, including administrative purpose and evaluation of the quality of care that you receive. In addition, state agencies may only request, receive, use and disclose patient health data solely as authorized by applicable law, or legally authorized by the individual.
- Opting Out – You have the choice to opt-out of having your electronic records viewed by participating members of the HIE at any time, by completing the opt-out form, which will be provided upon request. If you choose to opt-out of the HIE, your electronic records cannot be viewed or shared with other healthcare providers using the network. However, authorized healthcare providers will still be able to access your healthcare information on an as-needed basis to assist with continued care via phone, fax and/or regular mail. Until you submit a completed opt-out form or provide written notice that you are opting not to participate in the HIE, your electronic information is subject to be viewed amongst authorized members of HIE utilizing the system. Once received, it may take up to five business days to process the request. It is important to note that if another provider who treats you is a member of the HIE, if you do not opt-out with that particular provider, your information may still be viewed and shared via the HIE. You may opt back in by providing a written request and consent to have your electronic records shared.
- Potential Benefits of HIE Participation – Participation provides patients with several benefits, including; quick, secure and accurate sharing of patient information among authorized healthcare providers for improved and efficient patient care; reduction of duplicate medical tests; expedited information retrieval, increased patients’ face-to-face time with providers; and enhanced accuracy and efficiency in patient care.
- Potential Risks if HIE Participation – there are limited risks associated with your participation in HIE. The risks are managed through the HIE policies and federal HIPAA regulations, by which all participants must abide. You have a right to receive a list of occurrences that your health information was accessed, as well as for what purpose. In the even there is a breach of security which involves your health information, you will be notified per HIPAA regulations.

**AS REQUIRED BY LAW:** We will disclose medical information about you when required to do so by federal, state or local law.

**TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY:** We will disclose medical information about you 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.

**SPECIAL SITUATIONS:**

**RESEARCH:** We may also do certain types of research using your records, but only if a legally authorized review board give us permission to use your information and provided that the researcher says he/she will use safeguards to protect your information.

**ORGAN AND TISSUE DONATIONS:** If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantations.

**MILITARY AND VETRANS:** If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about

foreign military personnel to the appropriate authority. We may use and disclose information to the Department of Veterans Affairs to determine whether you are eligible for certain benefits.

**WORKERS COMPENSATION:** If applicable, we may release medical information about you for Workers Compensation or a similar program. These programs provide benefits for work-related injuries or illnesses.

**PUBLIC HEALTH RISKS:**

- \* To prevent or control disease, injury or disability
- \* To report deaths
- \* To report reactions to medications or problems with products
- \* To notify people of recalls of products they may be using
- \* To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition
- \* To notify the appropriate government authority if we believe you have been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

**HEALTH OVERSIGHT ACTIVITIES:** We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example; audits, investigations, inspections, and licensure. The activities are necessary for the government to monitor the health care system, government programs, and compliance with applicable civil rights laws.

**LAWSUITS AND DISPUTES:** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if we receive satisfactory assurances that the party seeking the information has made efforts to tell you about the request or to obtain an order protecting the information requested.

**LAW ENFORCEMENT:** we may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena (after we attempt to notify you), warrant, summons, or similar process
- To identify or locate a suspect, fugitive, material witness, or missing persons
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain your agreement
- About a death we believe may be the result of criminal conduct
- About criminal conduct at our office
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description of location of the person who committed the crime

**CORONERS, MEDICAL EXAMINERS, AND FUNERAL DIRECTORS:** We may release medical information to a coroner or medical examiner. This may be necessary. For example, to identify a deceased person or determine the cause of death. We may release medical information about patients of our office to funeral directors as necessary to carry out their duties.

**NATIONAL SECURITY AND INTELLIGENCE ACTIVITIES:** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

**PROTECTIVE SERVICES FOR THE PRESIDENT AND OTHERS:** We may disclose medical information about you to authorized federal officials, so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

#### **YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU:**

You have the following rights regarding medical information we maintain about you;

- **Right to Inspect and Copy:** You have the right to inspect and have copies of medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes and other mental health records in certain cases.
- To inspect and obtain copies of medical information that may be used to make decisions about you, you must submit your request in writing to our Privacy Officer or designee. If you request a copy of the information, we charge for the fees associated with retrieving, copying, mailing other supplies associated with your request.
- We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed if the denial is made for certain reasons. Another licensed health care professional chosen by our office will review your request and the denial. The person conducting the review will not be the person who initially denied your request. We will comply with the outcome of the review.

**RIGHT TO AMMEND:** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request and amendment for as long as the information is kept by or for our office.

To request an amendment, it must be made in writing and submitted by you to our Privacy Officer or designee. In addition, you must provide a reason that supports your request.

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:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment
- Is not a part of the medical information kept by our practice
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete

**RIGHT TO AN ACCOUNTING OF DISCLOSURES:** You have the right to request an “accounting of disclosures.” This is a list of certain disclosures we have made of medical information about you.

To request this list of accounting of disclosure, you must submit your request in writing to our Privacy Officer or designee. Your request must state a time period which may not start more than six years in the past and may not include dates before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before costs are incurred.

**RIGHT TO REQUEST RESTRICTION:** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or healthcare purposes. You may also request a limit on the medical information we disclose about you to someone involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information to your spouse.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment,

To request restrictions, you must submit your request in writing to our Privacy Officer or designee. Your request must include, 1. What information you want to limit. 2. Whether you want to limit our use, disclose or both, and 3. To whom you want the limited to apply, for example, disclosures to your spouse.

**RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the Privacy Officer or designee. We will not ask you the reason for your request. We will accommodate your request if it is reasonable. Your request must specify how or where to be contacted.

**RIGHT TO A PAPER COPY OF THIS NOTICE:**

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a copy of this notice.

To obtain a copy of this notice contact our Privacy Officer or designee at our address or visit our website at [www.urbanfamilypractice.org](http://www.urbanfamilypractice.org).

**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 medical information we already have about you as well as any information we receive in the future. The revision date will be listed in the top right corner of the notice.

**COMPLAINTS:**

If you believe your privacy rights have been violated, you may file a complaint with our office or Privacy Officer or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the Privacy Officer; 770.952.1032. Option 8. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

**OTHER USES OF MEDICAL INFORMATION:**

Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written permission. If you provide us permission to use or disclose medical 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 medical information about you for the reason 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 that care that we provide you.

If you have any questions, requests or complaints regarding privacy rights, please contact the Privacy Officer:

Urban Family Practice Associates, PC  
Attn: Privacy Officer  
2520 Windy Hill Road, SE, Suite 301  
Marietta, GA 30067  
770.952.1032

