

## ROCKY MOUNTAIN FAMILY MEDICINE, LLC NOTICE OF PRIVACY PRACTICES

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act 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.

\*\*\*\*\*Please review this notice carefully.

### A. Our commitment to your privacy:

our practice is dedicated to maintaining the privacy of your individually identifiable health information (protected health information or PHI). 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 PHI. 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 these laws are complicated, but we must provide you with the following important information:

- \* How we may use and disclose your PHI
- \* Your privacy rights in your PHI
- \* Our obligation concerning the use and disclose of your PHI

The terms of this notice apply to ALL records concerning your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any reversion or amendments to this notice will be effective for all of your records that our practice created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our office in a visible location at all time, and you may request a copy of our most current Notice at anytime.

### B. If you have any questions about this Notice, please contact:

The Office Manager @ (307)315-6133 or Fax (307)315-6134

### C. We may use and disclose your PHI in the following ways:

The following categories describe the different ways in which we may use and disclose your PHI.

1. Treatment: Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (blood or urine), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice- including but not limited to, our doctor's, nurse's, MA's, and receptionist- may use or disclose your PHI in order to treat you or to assist other's in your treatment. Additionally we may disclose your PHI to other's who may assist in your care, such as a spouse, children, or parent. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

2. Payment: Our practice may use and disclose your PHI in order 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 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 PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use and disclose your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health care options: Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

4. Appointment reminders: Our practice may use and disclose your PHI to contact you and remind you of an appointment.

5. Treatment options: Our practice may use and disclose your PHI to inform you of a potential treatment option or alternatives.

6. Health-related benefits and services: Our practice may use or disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

7. Optional Release of Information to family/friend's: Our practice may release your PHI to a family member or friend 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 doctor'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 PHI when we are required to do so by federal, state, or local law.

### D. Use and discloser of your PHI in special circumstances:

The following categories describe unique scenarios in which we may use or disclose your PHI:

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

- \* Maintaining vital records, such as births and deaths
- \* Reporting child abuse or neglect
- \* Preventing or controlling disease, injury, or disability
- \* Notifying a person regarding potential exposure to a communicable disease
- \* Notifying a person regarding a potential risk for spreading or contracting a disease or condition
- \* Reporting reactions to drugs or problems with products or devices
- \* Notifying individuals of a product or device that they may be using has been recalled
- \* Notifying appropriate government agency(ies) and authority(ies) regarding 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.
- \* Notify your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health oversight activities: Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, survey's, 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 PHI in response to a discovery request, subpoena or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you or the request or to obtain an order protecting the information the party has requested.

4. Law enforcement: We may release PHI 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 office
- \* In response to a warrant, summons, court order, subpoena or similar legal proceedings
- \* In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the

perpetrator).

5. Deceased patients: Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we may release information in order for funeral directors to perform their job's.

6. Organ and tissue donation: Our practice may release your PHI to organizations that handle organs, 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 PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when an Internal Review Board of Privacy Board has determined that the waiver of your authorization satisfies all of the following conditions:

(A) The use or disclosure involves no more than a minimal risk to your privacy based on the following: (i) an adequate plan to protect the identifiers from improper use and disclosure; (ii) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (iii) adequate written assurances that the PHI will not be re-used or disclosed to an other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted;

(B) The research could not practicably be conducted with the waiver;

(C) The research could not practicably be conducted without access to and use of PHI.

8. Serious threats to health or safety: Our practice may use and disclose your PHI when necessary to reduce or to 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 practices may disclose your PHI if you are a member of the U.S. or foreign military forces(including veterans) and if required by the appropriate authorities.

10. National security: Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI 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 PHI 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 institution to provide health care services to you, (b) for the safety and security of the institution, and/or to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation: Our practice may release your PHI for worker's compensation and similar programs.

E. Your rights regarding the PHI that we maintain about you:

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

Confidential communications: You have the right to request that our practices 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 the Office Manger(Fax: 307-315-6134) 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. Requesting restrictions: You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for 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 PHI, you must make a your request in writing to Office Manager(Fax:307-315-6133). Your request must describe in clear and concision:

- \* The information you wish restricted
- \* Whether you are requesting to limit our practice's use, disclosure or both,
- \* To who you want the limit to apply,

Inspection and copies: You have the right to inspect and obtain a copy of your PHI that may be used to make decisions about you, including your patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Office Manager(Fax:307-315-6134) in order to inspect and/or obtain a copy of your PHI. 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.

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 the information is kept by or from our practice. To request an amendment: Your request must be made in writing and submitted to Office Manager(Fax:307-315-6134). You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit 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: accurate and complete; (b) not one part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) generated by our practice, unless the individual or entity that created the information is not available to amend the information. Accounting or disclosures: all our patients have the right to request an "accounting of disclosures". An "accounting of disclosures" is a list of certain routine disclosures our practice has made of your PHI for purposes not related to treatment, payment or operations. Use of your PHI as part of the patient care in our practice is not required to be documented- for example, the doctor sharing information with the nurse/MA; or the billing department your information to file your insurance claim. In order to obtain an accounting disclosures, you must submit your request in writing to Office Manager (Fax:307-315-6134). All requests for an "accounting disclosures" must state a time period, which may not be longer than six (6) years from the date of service and may not include dates before August 1, 2009. The first list you request within a 12 month period is free of charge, but our practice may charge you for additional lists within the same 12 month period. Our practice will notify you of those costs involved with additional request, and you may cancel your request before you incur any costs.

Paper copy of this notice: You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this at any time. To obtain a paper copy of this notice, contact Office Manager (Fax:307-315-6134).

To file a complaint: If you believe your privacy rights have been violated, you must file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Office Manager (307-315-6133). All complaints must be in writing. You will not be penalized for filing a complaint.

To provide an authorization for other use and disclosures: Our office will obtain your written authorization for uses and disclosures that are covered by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked only in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note we are required to retain records of your care.

\*\*If you have any questions regarding this notice or our health information privacy policies, please contact Office Manager (Fax:307-315-6134).

\*\*\* I HAVE READ AND UNDERSTAND THE ABOVE STATEMENT AND AGREE TO ITS CONTENTS.

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

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