HIPAA Omnibus
Notice of Privacy Practices
Revised 2013

Effective Date: 9/1/2013

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.

OBLIGATION OF MOUNTAIN PODIATRY:

We are required by law to:

- Maintain the privacy of **Protected Health Information (PHI)**
- Give you this notice of our legal duties and privacy practices regarding health information on the patient
- Follow the terms of our notice that is currently in effect

This notice explains your rights and our legal obligations regarding the privacy of your **PHI.**
Protected Health Information **(PHI)** is information that individually identifies you. It may be used and disclosed by your physician, our office staff, another health care provider, your health plan, your employer, or a healthcare clearing house that relates to (1) your past, present, or future physical conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for your health care.

HOW MOUNTAIN PODIATRY, LTD MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION:

For Treatment: We may use and disclose your **PHI** to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example we may disclose your **PHI** to doctors, nurses, technicians, or other personnel, including people outside our office who are involved in your medical care and need the information to provide you with medical care.

For Payment: We may use and disclose your **PHI** to enable us or others to bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations: We may use and disclose your **PHI** for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the podiatry care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operations activities.

Appointment Reminders, Treatment Alternatives, Health Related Benefits and Services: We may use and disclose your **PHI** to contact you to remind you that you have a scheduled medical appointment with us. We also may use and disclose your **PHI** to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved In Your Care or In Payment For Your Care: When appropriate we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

As Required by Law: We will disclose your **PHI** about you when required to do so in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your **PHI** when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your **PHI** for marketing purposes. We may not sell your **PHI** without your authorization. We may not use or disclose most psychotherapy notes contained in your **PHI**. We will not use or disclose any of your **PHI** that contains genetic information that will be used for underwriting purposes. You may revoke the authorization at any time by submitting a written revocation and we will no longer disclose your **PHI,** except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

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YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION (PHI).

The following are statements of your rights with respect to your Protected Health Information (PHI):

You Have The Right To Inspect and Copy Your PHI (fees may apply): Pursuant to your written request, you have the right to inspect or copy your **PHI** for the purposes of treatment, payment or healthcare operations. You have a right to request a summary of your **PHI** instead of the entire record, or an explanation of your **PHI** which has been provided to you so long as you agree to this alternative form and agree to pay the associated fees.

You Have The Right To An Electronic Copy of Electronic Medical Records (fees may apply): You have the right to request to be given to you or have transmitted to another individual or entity, an electronic copy of your **PHI,** if they are maintained in an electronic format. We will make every effort to provide the electronic copy in the format you request however if it is not readily producible by us we will provide it in either our standard format or in hard copy form.

You Have The Right To Request Restrictions Of Your PHI: This means you may ask us not to use or disclose any part of your **PHI** for the purpose of treatment, payment or healthcare operations. You may also request that any part of your **PHI** not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose your **PHI** to your health plan with respect to healthcare for which you have paid in full out of pocket.

You Have The Right To Receive Confidential Communications: This means you may request that we communicate with you only in certain ways to reserve your privacy. For example, you may request that we contact you by mail at a specific address or call you on a specific telephone number. Your request must be made in writing with specific instructions on how and where we contact you. We will accommodate all reasonable requests and will not ask the reason for your request.

You Have The Right To Request An Amendment To Your PHI: If you feel that your **PHI** is incorrect or incomplete, you may ask us to amend the information. A request and the reason for the requested amendment must be made in writing to the HIPAA Compliance Officer (information located at the end of this Notice). In certain cases we may deny your request. If we deny your request you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you a copy.

You Have The Right To Get A Notice Of A Breach: You have the right to be notified upon a breach of any of your unsecured **PHI.**

You Have The Right To Receive An Accounting of Disclosures: You have the right to receive an accounting of all disclosures paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request. Your request must be made in writing and you must indicate in what form you want the list, for example on paper or electronically.

COMPLAINTS:

You may file a complaint with us or with the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated. To file a complaint with us you must make it in writing to our HIPAA Compliance Officer at the information at the end of this Notice. Complaints must be submitted within 180 days of when you knew of or suspected the violation. **There will be no retaliation against you for filing a complaint.** To file a complaint with the Secretary, mail it to: Secretary of the U.S. Dept. of Health and Human Services, 200 Independence Avenue, S.W. Washington, D.C. 20201. Call (202) 619-0257 or toll free (877)-696-6775 or go to the website of the Office of Civil Rights, www.hhs.gov/ocr/hippa/, for more information. **There will be no retaliation against you for filing a complaint.**

If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at the information at the end of this Notice. You have the right to request a paper copy of this Notice at any time even if you have agreed to receive this Notice electronically. A copy of this Notice may also be found on our website.

Please sign the accompanying "Acknowledgement" form. Please note that by signing the Acknowledgment for you are only acknowledging that you have received a copy of our Notice of Privacy Practices.

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