

# ALEXANDRIA WOMEN'S CENTER NOTICE OF PRIVACY PRACTICES

Effective Date: September 23, 2013

**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 the Practice's Privacy Official by dialing the Practice's main number {318}443-7222.

## **Our Responsibilities**

We are required by law to maintain the privacy of your health information, provide you a description of our privacy practices, and to notify you following a breach of unsecured protected health information. You have certain rights and we have certain legal obligations regarding the privacy of your Protected Health Information, and this Notice also explains your rights and our obligations. We will abide by the terms of this Notice.

## **Uses and Disclosures**

### **How we may use and disclose Health Information about you.**

The following categories describe examples of the way we may use and disclose your health information:

**For Treatment:** We may use health information about you to provide you medical treatment or services. We may disclose health information about you to doctors, nurses, and technicians, medical students, or other Practice personnel who are involved in taking care of you. For example, your health information may be provided to a physician or other health care provider to which you have been referred.

**For Payment:** We may use and disclose health information about your treatment and services to bill and collect payment from you, your insurance company or a third party payer. For example, we may need to give your insurance company information about your surgery or other health care services so they will pay us or reimburse you for the treatment. We may also tell your health plan about treatment you are going to receive to determine whether your plan will cover it.

**For Health Care Operations:** Our Physicians may use information in your health record to assess the care and outcomes in your case and others like it. The results will then be used to continually improve the quality of care for all patients we serve. For example, we may combine health information about many patients to evaluate the need for new services or treatment. We may disclose information to doctors, nurses, and other students for educational purposes. And we may combine health information we have with that of other facilities to see where we can make improvements. We may remove information that identifies you from this set of health information to protect your privacy.

We may also use and disclose health information:

- To remind you that you have an appointment for medical care;
- To assess your satisfaction with our services;
- To tell you about possible treatment alternatives;
- To tell you about health-related benefits or services;
- For population based activities relating to improving health or reducing health care costs; and
- For conducting training programs or reviewing competence of health care professional;

When disclosing information, primarily appointment reminders and billing/collections efforts, we may leave messages on your answering machine/voice mail.

**Business Associates:** There are some services provided in our organization through contracts with business associates. Examples include billing companies, transcription companies, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, business associates are required by federal law to appropriately safeguard your information.

**Individuals Involved in Your Care or Payment for Your Care and/or Notification Purposes:** We may release health information about you to a friend or family member who is involved in your Medical care or who helps pay for your care or to notify, or assist in the notification of (including identifying or locating), a family member, your personal representative, or another person responsible for your care of your location and general condition. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort in order to assist with the provision of this notice.

**Research:** The use of health information is important to develop new knowledge and improve medical care. We may use or disclose health information for research studies but only when they meet all federal and state requirements to protect your privacy (such as using only de-identified data whenever possible). You may also be contacted to participate in a research study.

**Future Communications:** We may communicate to you via newsletters, mail outs or other means regarding treatment options, health related information, disease-management programs, wellness programs, research projects, or other community based initiatives or activities our Practice participates in.

**Health Information Exchange/Regional Health Information Organization:** Federal and state laws may permit us to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share your health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of your health records; decreasing the time needed to access your information; aggregating and comparing your information for quality improvement purposes; and such other purposes as may be permitted by law.

**When We Must Obtain Your Authorization:** We must obtain your authorization before using or disclosing health information for the following purposes:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

**As required by law.** We may disclose information when required to do so by law.

**As permitted by law,** we may also use and disclose health information for the following types of entities, including but not limited to:

- Food and Drug Administration
- Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability
- Correctional Institutions
- Workers Compensation Agents
- Organ and Tissue Donation Organizations
- Military Command Authorities
- Health Oversight Agencies
- Funeral Directors and Coroners
- National Security and Intelligence Agencies
- Protective Services for the President and Others
- t A person or persons able to prevent or lessen a serious threat to health or safety

**Law Enforcement:** We may disclose health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.

**For Judicial or Administrative Proceedings:** We may disclose protected health information as permitted by law in connection with judicial or administrative proceedings, such as in response to a court order, search warrant or subpoena.

**State-Specific Requirements:** Many states have requirements for reporting including population-based cities relating to improving health or reducing health care costs. Some states have separate privacy laws that may apply additional legal requirements. If the state privacy laws are more stringent than federal privacy laws, the state law preempts the federal law.

**Fundraising:** We may contact you for fundraising efforts, but you can tell us not to contact you again.

### **Your Rights Regarding Your Protected Health Information**

You have the following rights, subject to certain limitations, regarding your Protected Health Information:

- **Right to Inspect and Copy:** You have the right to inspect and obtain a copy of the health information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. 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 the Practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.
- **Right to Request an Amendment:** If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the facility. Any request for an amendment must be sent in writing to the Practice Privacy Official.

We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial.

- **Right to Restrict Uses or Disclosures:** You have a right to ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.

If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

- **An Accounting of Disclosures:** You have the right to request an accounting of disclosures. This is a list of certain disclosures we make of your health information for purposes other than treatment, payment or health care operations where an authorization was not required.

We are required to agree to your request only if 1) except as otherwise required by law, the disclosure is to your health plan and the purpose is related to payment or health care operations (and not treatment purposes), and 2) your information pertains solely to health care services for which you have paid in full. For other requests, we are not required to agree. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

- **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 may ask that we contact you at work instead of your home. The Practice will grant reasonable requests for confidential communications at alternative locations and/or via alternative means only if the request is submitted in writing and the written request includes a mailing address where the individual will receive bills for services rendered by the Practice and related correspondence regarding payment for services. Please realize, we reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response. We will notify you in accordance with your original request prior to attempting to contact you by other means or at another location.

- **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 paper copy of this notice.

If the Practice has a website you may print or view a copy of the notice by clicking on the Notice of Privacy Practices link.

To exercise any of your rights, please obtain the required forms from the Privacy Official and submit your request in writing.

## **CHANGES TO THIS NOTICE**

We reserve the right to change this notice and the revised or changed notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in the Practice and on our website and include the effective date. In addition, each time you register at or are admitted to the Practice for treatment or health care services as an inpatient or outpatient, 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 the Practice by following the process outline in the facility's Patient Rights documentation. You may also file a complaint with the Secretary of the Department of Health and Human Services. 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 use will be made only with your written authorization. If you provide us permission to use or disclose health information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, 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 authorization, and that we are required to retain our records of the care that we provided to you.

**PRACTICE PRIVACY OFFICIAL : Cheryl Lueng**

Telephone Number: (318)443-7222

**ALEXANDRIA WOMEN'S CENTER**

**AUTHORIZATION FOR RELEASE OF PROTECTED INFORMATION**

**1. PATIENT INFORMATION**

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

PATIENT ADDRESS: \_\_\_\_\_  
STREET CITY STATE ZIP

PATIENT HOME PHONE: \_\_\_\_\_ PATIENT EMAIL: \_\_\_\_\_

**2. RECIPIENT AUTHORIZATION**

I \_\_\_\_\_ hereby authorize \_\_\_\_\_ to release a copy of my medical records to **Alexandria Women's Center 3304 Masonic Dr. Ste 4001 Alexandria, LA 71301**

**3. INFORMATION TO BE RELEASED**

- Entire Medical Record \_\_\_\_\_
- Lab Reports \_\_\_\_\_
- Visit Notes \_\_\_\_\_
- X-ray Reports \_\_\_\_\_
- Pathology Reports \_\_\_\_\_
- Other (specify) \_\_\_\_\_
- Psychotherapy Notes \_\_\_\_\_ (If so, this is the only item you may request on this authorization)

**4. PURPOSE OF INFORMATION RELEASE**

- Further medical care
- Disability Determination
- Payment of insurance claim
- Vocational Rehab, evaluation
- Legal investigation
- At the request of the individual
- Applying for insurance
- Other (specify)

**5. INCLUSION OF PRIVILEGED INFORMATION**

I understand that if my record contains information concerning alcohol or drug abuse/treatment, information concerning abortion, HIV testing and related information, AIDS-related conditions, genetic testing, STDs, domestic/sexual abuse, or developmental disabilities, such information is included in this disclosure.

**4. PATIENT RIGHTS AND PRIVACY**

- I understand that I do not have to sign the authorization in order to receive treatment or payment, or to enroll or be eligible for benefits. I understand that I may revoke this authorization at any time, except to the extent that the individual or entity that is to make the disclosure has already completed action on it.
- I understand that protected health information disclose pursuant to this authorization may be re-disclosed by the recipient to other individuals or organizations that are not subject to privacy protection laws.
- I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I request it.
- **This authorization will automatically expire one year from the date signed.**

SIGNATURE OF PATIENT \_\_\_\_\_ DATE: \_\_\_\_\_

SIGNATURE OF LEGAL REPRESENTATIVE \_\_\_\_\_ DATE: \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_