



## HILLSIDE DERMATOLOGY'S NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

### **Our Pledge And Legal Duty To Protect Health Information About You.**

The privacy of your health information is important to us. We are required by federal and state laws to protect the privacy of your health information. We refer to this information as protected health information, or PHI. We must give you notice of our legal duties and privacy practices concerning PHI, including:

- We must protect PHI that we have created or received about your past, present, or future health condition, health care we provide to you, or payment for your health care.
- We must notify you about how we protect PHI about you.
- We must explain how, when and why we use and/or disclose PHI about you.
- We may only use and/or disclose PHI as we have described in this Notice. We must abide by the terms of this Notice.

We are required to abide by the terms of this Notice. We reserve the right to change the terms of this Notice and to make new notice provisions effective for all PHI that we maintain. We will post a revised notice in our offices, make copies available to you upon request and post the revised notice.

Ohio Patient Consent for Disclosures

For most disclosures of your health information we are required by State of Ohio Laws to obtain a written consent from you, unless the disclosure is authorized by Law. This consent may be obtained at the beginning of your treatment, during the first delivery of health care service, or at a later point in your care, when the need arises to disclose your health information to others outside of our organization.

## **USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION**

### **A. Uses and Disclosures of Your Protected Health Information for Purposes of Treatment, Payment and Health Care Operations.**

**Health Care Treatment.** We may use and disclose PHI about you to provide, coordinate or manage your health care and related services. This may include communicating with other health care providers regarding your treatment and coordinating and managing the delivery of health services with others. For example, we may use and disclose PHI about you when you need a prescription, lab work, an x-ray, or other health care services. In addition, we may use and disclose PHI about you when referring you to another health care provider.

**Payment.** We may use and disclose your medical information to others to bill and collect payment for the treatment and services provided to you. For example: A bill may be sent to you or a third party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used. Before you receive scheduled services, we may share information about these services with your health plan(s). Sharing information allows us to ask for coverage under your plan or policy and for approval of payment before we provide the services. We may also share portions of your medical information with the following: 1) Billing departments; 2) Collection departments or agencies; 3) Insurance companies, health plans and their agents which provide you coverage; 4) Utilization review personnel that review the care you received to check that it and the costs associated with it were appropriate for your illness or injury; and 5) Consumer reporting agencies (e.g., credit bureaus).

**Health Care Operations.** We may use and disclose PHI in performing business activities, which we call health care operations. For example: Members of our staff such as the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

**Our Business Associates.** There are some services provided in our organization through contacts with business

associates. Examples include physician services in the Emergency Department and Radiology, certain laboratory tests, 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 associate so that they can perform the job we've asked them to do and bill you or your third party payer for services rendered. So that your health information is protected, however, we require the business associate to sign a contract ensuring their commitment to protect your PHI consistent with this Notice and to appropriately safeguard your information.

### **C. Uses and Disclosures of Your Protected Health Information that Require Your Authorization.**

In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization, different from the Minnesota Patient Consent, to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

- Research: We may disclose information to external researchers with your authorization, which we will attempt to collect in a manner consistent with applicable state laws.
- Marketing: We will not be able to use or disclose your name, contact information or other PHI for purposes of marketing without your written authorization. This does not include informing you about treatment alternatives or other health related products or services that may be of interest to you.

### **D. Uses and Disclosures of Your Protected Health Information that Require Your Opportunity to Agree or Object.**

In the following instances we will provide you the opportunity to agree or object to a use or disclosure of your PHI:

- Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.
- Communication with Family: Health professionals, using their best judgement, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

If you would like to object to our use or disclosure of PHI about you in the above circumstances, please call our contact person listed on the cover page of this Notice.

### **E. Use And Disclosure Authorized by Law that Do Not Require Your Consent, Authorization or Opportunity to Agree or Object.**

Under certain circumstances we are authorized to use and disclose your health information without obtaining a consent or authorization from you or giving you the opportunity to agree or object. These include:

- When the use and/or disclosure is authorized or required by law. For example, when a disclosure is required by federal, state or local law or other judicial or administrative proceeding.
- When the use and/or disclosure is necessary for public health activities. For example, we may disclose PHI about you if you have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition.
- When the disclosure relates to victims of abuse neglect or domestic violence.
- When the use and/or disclosure is for health oversight activities. For example, we may disclose PHI about you to a state or federal health oversight agency which is authorized by law to oversee our operations.
- When the disclosure is for judicial and administrative proceedings. For example, we may disclose PHI about you in response to an order of a court or administrative tribunal.
- When the disclosure is for law enforcement purposes. For example, we may disclose PHI about you in order to comply with laws that require the reporting of certain types of wounds or other physical injuries.
- When the use and/or disclosure relates to decedents. For example, we may disclose PHI about you to a coroner or medical examiner, consistent with applicable laws, to carry out their duties.
- When the use and/or disclosure relates to products regulated by the Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects or post marketing surveillance information to enable product recalls, repairs or replacement.

- When the use and/or disclosure relates to cadaveric organ, eye or tissue donation purposes. Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant. When the use and/or disclosure relates to Worker's Compensation information: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.
- When the use and/or disclosure is to avert a serious threat to health or safety. For example, we may disclose PHI about you to prevent or lessen a serious and eminent threat to the health or safety of a person or the public.
- When the use and/or disclosure relates to specialized government functions. For example, we may disclose PHI about you if it relates to military and veterans activities, national security and intelligence activities, protective services for the President, and medical suitability or determinations of the Department of State.
- When the use and/or disclosure relates to correctional institutions and in other law enforcement custodial situations. For example, in certain circumstances, we may disclose PHI about you to a correctional institution having lawful custody of you.

## **YOUR INDIVIDUAL RIGHTS**

### **A. Right to Request Restrictions on Uses and Disclosures of PHI.**

You have the right to request that we restrict the use and disclosure of PHI about you. We are not required to agree to your requested restrictions. However, even if we agree to your request, in certain situations your restrictions may not be followed. These situations include emergency treatment, disclosures to the Secretary of the Department of Health and Human Services, and uses and disclosures described in subsection 4 of the previous section of this Notice. You may request a restriction by submitting your request in writing to us. We will notify you if we are unable to agree to your request.

### **B. Right to Request Communications via Alternative Means or to Alternative Locations.**

Periodically, we will contact you by phone, email, postcard reminders, or other means to the location identified in our records with appointment reminders, results of tests or other health information about you. You have the right to request that we communicate with you through alternative means or to alternative locations. For example, you may request that we contact you at your work address or phone number or by email. While we are not required to agree with your request, we will make efforts to accommodate reasonable requests. You must submit your request in writing.

### **C. Right to See and Copy PHI.**

You have the right to request to see and receive a copy of PHI contained in clinical, billing and other records used to make decisions about you. Your request must be in writing. We may charge you related fees. Instead of providing you with a full copy of the PHI, we may give you a summary or explanation of the PHI about you, if you agree in advance to the form and cost of the summary or explanation. There are certain situations in which we are not required to comply with your request. Under these circumstances, we will respond to you in writing, stating why we will not grant your request and describing any rights you may have to request a review of our denial.

### **D. Right to Request Amendment of PHI.**

You have the right to request that we make amendments to clinical, financial and other health-related information that we maintain and use to make decisions about you. Your request must be in writing and must explain your reason(s) for the amendment and, when appropriate, provide supporting documentation. We may deny your request if: 1) the information was not created by us (unless you prove the creator of the information is no longer available to amend the record); 2) the information is not part of the records used to make decisions about you; 3) we believe the information is correct and complete; or 4) you would not have the right to see and copy the record as described in paragraph 3 above. We will tell you in writing the reasons for the denial and describe your rights to give us a written statement disagreeing with the denial. If we accept your request to amend the information, we will make reasonable efforts to inform others of the amendment, including persons you name who have received PHI about you and who need the amendment.

### **E. Right to Request and Accounting of Disclosures of PHI.**

You have the right to a listing of certain disclosures we have made of your PHI. You must request this in writing.

You may ask for disclosures made up to six (6) years before the date of your request (not including disclosures made prior to April 14, 2003). The list will include the date of the disclosure, the name (and address, if available) of the person or organization receiving the information, a brief description of the information disclosed, and the purpose of the disclosure. If, under permitted circumstances, PHI about you has been disclosed for certain types of research projects, the list may include different types of information. If you request a list of disclosures more than once in 12 months, we can charge you a reasonable fee.

**F. Right to Receive a Copy of This Notice.**

You have the right to request and receive a paper copy of this Notice at any time. We will provide a copy of this Notice no later than the date you first receive service from us (except for emergency services or when the first contact is not in person, and then we will provide the Notice to you as soon as possible).

**QUESTIONS OR COMPLAINTS**

If you want more information about our privacy practices or have questions or concerns, please contact our Privacy Official. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may file a complain with our Privacy Official. You can also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

**Privacy Office Contact Information**

**Address: 200 SILVER STREET, SUITE 106**

**Telephone: (413)-341-5350 Fax: (413)-341-5335**



## General Release and Acknowledgement of Receipt of Notice of Privacy Practices

I, \_\_\_\_\_, acknowledge and agree that I have had the right to review a copy of the Hillside Dermatology Notice of Privacy Practices prior to signing this consent, which provided me a more complete description of potential uses and disclosures of my protected health information (PHI). I hereby consent to Hillside Dermatology physicians/providers, outside providers who are involved in my care, organized health care arrangements ("OHCA") with which Hillside Dermatology participates as well as other providers within the OHCA, networks such as IPAs and accountable care organizations that coordinate care for providers who may treat me, and insurers to obtain payment. I am aware that Hillside Dermatology disclaims any liability or harm resulting from my incorrect or incomplete provision of my primary care physician's contact information, and that Hillside Dermatology reserves the right to revise its Notice of Privacy Practices at any time. I am also aware that an updated copy of Hillside Dermatology's Notice of Privacy Practices is available on Hillside Dermatology's website.



\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Date



\_\_\_\_\_  
Signature of Patient's legal representative (if applicable)

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Date