

Blairsville Internal Medicine

Mary Beth Wiles, MD Elizabeth Wiles, DO Jill Nielsen, DNP Suzanna Pollock, APRN

NOTICE OF PRIVACY PRACTICES

Effective April 14, 2003

As required by the privacy regulations created by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This notice describes how health information about you (as a patient of the practices named below) may be used and disclosed and how you can get access to your individually identifiable health information.

A. OUR COMMITMENT TO YOUR PRIVACY: As health care providers, we use your confidential health information and create records regarding that health information in order to provide you with quality care and to comply with certain legal requirements. Our practices are dedicated to maintaining the privacy of your individually identifiable health information (also called protected health information, or **PHI**). This Notice applies to records of your care created or maintained by our practices. We are required by law to: (1) make sure we have reasonable processes in place to keep your health information private; (2) give you this Notice of our legal duties and privacy practices with respect to your health information; and (3) follow the terms of the Notice that are currently in effect.

B. IF YOU HAVE QUESTIONS: contact: Privacy Officer, PO Box 1000, Blairsville, GA 30514.

C. HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR AUTHORIZATION: We may use health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Continuity of care is part of treatment and your records may be shared with other providers you choose to see or to whom you are referred. Information may be shared by paper mail, electronic mail, fax, or other methods. We may use or disclose identifiable health information about you without your authorization in certain situations; but beyond those situations, we will ask for your written authorization before using or disclosing any identifiable health information about you. The following information describes different ways that we may use or disclose your health information without your authorization.

1. Treatment. Our practice(s) may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), 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(s) – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice(s) 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 that 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 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 operations. Our practices may use and disclose your PHI to operate our business. For example, we may use health information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

4. Health Information Exchanges (HIE). Health information exchanges allow health care providers to share and receive information about patients, which assists in the coordination of patient care. Your health information may be included in the health information exchange. We may also make your health information available to other health exchange services that request your information for coordination of your treatment and/or payment for services rendered to you. Participation in the health information exchange is voluntary, and you have the right to opt out by writing: Privacy Officer, PO Box 1000, Blairsville GA 30514. **At present, we are not members of a Health Information Exchange.**

5. Appointment reminders, Follow-up Calls and Treatment Alternatives. We may use or disclose health information to remind you that you have an appointment or to check on you after you have received treatment. If you have an answering machine we may leave a message. If you elect, we may also send appointment reminders via text message or email. We also may send you a letter or post card appointment reminder. We may contact you about possible treatment options or alternatives or other health related benefits or services that may be of interest to you.

6. Individuals Involved in Your Care or Payment for Your Care. According to your preferences, we may disclose health information to a friend or family member who is involved in your medical care or who assists in taking care of you. We may also give information to someone who helps pay for your care. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

7. Records Research. We may use or disclose health information under certain circumstances for medical research purposes. For example, a research project may compare the health of patients who received one medication to those who received another for the same condition. We will obtain your written authorization to use or disclose your health information for research purposes **except when** (a) an Institutional Review Board (IRB) determines in advance that use or disclosure of your health information meets specific criteria required by law; or (b) the researcher signs a legally binding document certifying that he/she will only use the health information to prepare a research protocol or for similar purposes to prepare for a research project and that he/she will maintain the confidentiality of the information and will not remove any of the health information from our practices.

8. Disclosures required by law. Our practices will use and disclose your PHI when we are required to do so by federal, state or local law.

9. To Avert a Serious Threat to Health or Safety. We may use or disclose health information when necessary to prevent a serious threat to your health and safety, or the health and safety of another person or the public. Any disclosure, however, would only be to someone able to help prevent the threat.

D. Use and disclosure of your PHI in certain special circumstances:

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. Organ and Tissue Donation. 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 transplantation.

2. Military and Veterans. To military command authorities as required, if you are a member of the armed forces. We may also disclose health information about foreign military personnel to the appropriate foreign military authority.

3. Workers' Compensation. To workers' compensation or similar programs that provide benefits for work-related injuries or illness.

4. Public health Activities. To public health agencies or other governmental authorities to report public health activities or risks. These activities generally include the following: to prevent or control disease, injury or disability; to report births and deaths; to report child abuse or neglect; 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 as authorized by law; to notify the appropriate government authority if we believe a patient has 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).

5. Health Oversight Activities. To a health oversight agency for activities authorized by law. These oversight activities include for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

6. Lawsuits and Disputes. In response to a court or administrative order if you are involved in a lawsuit or a dispute. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the health information requested.

7. Law Enforcement. In response to a court order, subpoena, warrant, summons or similar process; or upon request by a law enforcement official to identify or locate a suspect, fugitive, material witness, or missing person or to obtain information about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's authorization. We may report a death that we believe may be the result of criminal conduct or report suspected criminal conduct occurring on the premises. We may also report information related to a suspected crime discovered in the course of providing emergency medical services.

8. Coroners, Medical Examiners and Funeral Directors. 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 also release health information about patients of our practices to funeral directors as necessary to carry out their duties.

9. National Security and Intelligence Activities. To authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

10. Protective Services for the President and Others. To authorized federal officials so they may provide protection to the President of the United States, other authorized persons or foreign heads of state or conduct special investigations.

11. Inmates. To the correctional institution or law enforcement official, if you are an inmate of a correctional institution or under the custody of a law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

E. USES AND DISCLOSURES WHICH REQUIRE YOUR AUTHORIZATION

Most uses and disclosures of psychotherapy notes, any uses and disclosures for marketing purposes, disclosures that constitute a sale of health information, and other types of uses and disclosures of your health information not described in this Notice require an authorization and will be made only with your special written authorization. You may revoke your authorization by giving written notice to Privacy Officer, PO Box 1000, Blairsville GA 30514. If you revoke this special authorization, we will no longer use or disclose your health information as permitted by your initial authorization. Please understand that we will not be able to take back any disclosures we have already made and that we are still required to retain our records containing your health information that documents the care that we provided to you.

F. YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

1. Right to Inspect and Copy. You have the right to inspect and obtain a copy of your medical record or billing record. To inspect and copy your medical or billing record, you must submit your request in writing to the Privacy Officer, PO Box 1000, Blairsville GA 30514. You need to include in your request your name, or if acting as a personal representative, include the name of the patient, your contact information, date of birth and dates of service if known. To the extent that your health information is maintained electronically and you request the information in an electronic format, to the extent possible we will provide you a machine readable copy. If you request a copy, you will be charged a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy records in certain limited circumstances; however, you may request that the denial be reviewed. A licensed health care professional chosen by our practices 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. Our practices might not retain medical records from other facilities for inclusion in your medical record or designated record set. These could include radiology films, scans or compact discs that were or might be provided to your provider in these practices.

2. Right to Request an Amendment. If you feel that health information we have about you is incorrect, you may ask us to amend it. You have the right to request an amendment for as long as the health information is kept by or for our practices. To request an amendment, your request must be made in writing and submitted to: Medical Records, PO Box 1000, Blairsville GA 30514. In addition, you must provide a reason that supports your request. You need to include in your request your name, contact information, date of birth and dates of service if known. If you are acting as a personal representative, include the name of the patient, your contact information, date of birth and dates of service if known. 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 health information that:

- Was not created by us, unless the person or entity that created the health information is no longer available to make the amendment;

- Is not part of the health information kept by or for our practices;
- Is not part of the health information which you would be permitted to inspect and copy; or
- Is accurate and complete.

3. Right to an Accounting of Disclosures. You have the right to request a list of the disclosures we made of your health information except for disclosures:

- for treatment, payment or healthcare operations,
- pursuant to an authorization,
- incident to a permitted use or disclosure, or
- for certain other limited disclosures defined by law.

To request this list of disclosures, you must submit your request in writing to the Privacy Officer, PO Box 1000, Blairsville GA 30514. Your request must specify a time period for which you are seeking an accounting of disclosures and include your name, contact information, date of birth and dates of service if known. If you are acting as a personal representative, include the name of the patient, your contact information, date of birth and dates of service if known. You may not request disclosures that are more than six years from the date of your request or that were before April 14, 2003. Your request should indicate in what form you want the list, for example, on paper or electronically. 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 any costs are incurred.

4. Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. Except as otherwise required by law, we will comply with a request to restrict disclosure of health information to a health plan for purposes of carrying out payment or healthcare operations, BUT ONLY if the health information you ask to be restricted from disclosure pertains solely to a health care item or service for which you have paid out of pocket, in full. **We are not required to agree to any other requests.** If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. We have the right to revoke our agreement at any time, and once we notify you of this revocation, we may use or disclose your health information without regard to any restriction or limitation you may have requested. To request restrictions, you must make your request in writing to the Privacy Officer, PO Box 1000, Blairsville GA 30514. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

5. 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, PO Box 1000, Blairsville GA 30514. You will need to include your name, or if acting as a personal representative, include the name of the patient, contact information, date of birth and dates of service if known. We will not ask you the reason for your request. We will work to accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

6. Right To Receive a Paper Copy of This Notice. Even if you have agreed to receive this Notice electronically, you have the right to receive a paper copy of this Notice, which you may ask for at any time. You may obtain a copy of this Notice at our website or by writing to Privacy Officer, PO Box 1000, Blairsville, GA 30514.

7. Right to Receive Notification of a Breach of Your Health Information. We have put in place reasonable processes and procedures to protect the privacy and security of your health information. If there is an unauthorized acquisition, access, use, or disclosure of your protected health information we will notify you as required by law. The law may not require notice to you in all cases. In some situations, even if the law does not require notification, we may choose to notify you.

G. 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 health information we already have about you as well as any information we receive in the future. We provide a copy of the current Notice at our facilities and you may request a copy of the current notice.

H. COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint by writing to Privacy Officer, PO Box 1000, Blairsville GA 30514. You may also file a complaint with the Secretary of the Department of Health and Human Services, <http://www.hhs.gov/ocr/privacy/hipaa/complaints>. You will not be penalized for filing a complaint.

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