

Model HIPAA Notice of Privacy Practices

Letterhead: Physician/Practice Name

Effective Date: _____

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. *(Note: this specific language must be prominently included in the notice.)*

If you have any questions about this notice, please contact our privacy officer: *insert name and contact information here.* _____

PRACTICE RESPONSIBILITIES:

We are required by law to maintain the privacy of your health information, to provide you with notice of our privacy practices and to notify you of any breach of your health information. We are committed to protecting the privacy and security of your health information and will follow the terms of our notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION:

This notice describes how we may use and disclose health information that identifies you. The notice includes a number of examples, but does not list every use or disclosure. If you have specific questions, please contact our practice's privacy officer. Except for the purposes described below, we will use and disclose health information only with your written permission or authorization. You may revoke such permission at any time by writing to our practice's privacy officer.

The notice must include at least one example, of the types of uses and disclosure that you make for treatment, payment and health care operations. The examples below are illustrative, and you should tailor them to your practice.

For Treatment. We may use and disclose health information to provide treatment to you, and to coordinate your health care and treatment-related services. For example, we may disclose your health information to doctors, nurses, technicians, pharmacies, labs, home health agencies 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 health information so that we or others may bill and receive payment from you, from an insurance company or from another 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. We may use or disclose information to insurers obtain prior approval for drugs we prescribe for you, or medical services like hospital admissions.

For Health Care Operations. We may use and disclose health information for uses and disclosures that are necessary to operate and manage our office and to review our care to make sure that all of our patients receive quality care. For example, we may use and disclose information to make sure the 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 operation activities. If we disclose health information to third parties, such as billing services, they will sign a “business associate agreement” that obligates them to protect your health information in the same manner that we protect it.

Appointment Reminders We may contact you to remind you that you have an appointment with us.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share your 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.

WE MAY DISCLOSE INFORMATION WITHOUT YOUR AUTHORIZATION IN CERTAIN CASES INCLUDING :

As Required by Law. We will disclose health information when required to do so by international, federal, state or local law.

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

Business Associates. We may disclose health information to business associates that provide us with services, if the information is necessary for the services. For example, we may use another company to perform billing services on our behalf, or consult with us about our electronic records. All of our business associates are obligated to protect the privacy of your information and are not permitted to use or disclose any health information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release health information to organizations that handle organ procurement or other related entities to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release health information as required by military command authorities.

Workers' Compensation. We may release health information for workers' compensation or similar programs.

Public Health and Population Health Activities. We may disclose health information when required or authorized by law for public health activities such as reporting diseases, certain injuries, complying with Food and Drug Administration requirements. We may also disclose information to report births and deaths, child abuse or neglect.

Health Oversight Activities. We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities may include, for example, audits, investigations, inspections, and licensure.

Breach Notification Purposes. We may use or disclose your health information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits, Law Enforcement and Medical Examiners. If you are involved in a lawsuit or dispute, we may disclose health information in response to a court or administrative order. We may release health information to a law enforcement official in certain specific circumstances such as when a crime occurs on our premises. We may release health information to a medical examiner, to identify a deceased person or determine the cause of death.

National Security Activities. We may release health information to federal officials for national security activities authorized by law.

Disclosures required by Vermont law. Vermont law requires certain types of disclosures including reporting child abuse; abuse, neglect or exploitation of vulnerable adults; fire-arm related injuries; communicable diseases; fetal deaths; cancer; lead poisoning; and blood-alcohol content. Vermont requires written consent for some uses and disclosures covered by this notice. **Note: you may obtain a general consent from the patient that complies with Vermont law and enables you to make disclosures authorized by HIPAA, when you obtain the acknowledgment that the patient has received the Notice of Privacy Practices.**

WE MUST GIVE YOU AN OPPORTUNITY TO OBJECT/OPT OUT FOR CERTAIN DISCLOSURES

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your health information. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your health information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

Fundraising. Physician practices may use your health information to target fundraising communications, including your treating physician and department of service. ***You may opt-out of fundraising communications by contacting _____.*** We will honor your opt out, permit you to opt back in and will not condition treatment on your decision. ***(Note: only required if applicable to your practice.)***

WRITTEN AUTHORIZATION REQUIRED FOR CERTAIN USES AND DISCLOSURES

The following uses and disclosures of your health information will be made only with your written authorization:

Marketing. When uses and disclosures of your health information are made for marketing purposes, you must authorize the disclosure in writing and the authorization must state that the communication is paid for.

Sale. When disclosures constitute a sale of your health information; you must authorize the disclosure and the authorization must state that the disclosure will result in payment for the information.

Psychotherapy Notes. We must have your authorization in order to use or disclose psychotherapy notes unless certain exceptions apply i.e. the notes are needed for use by the originator of the notes, for use in training programs, to defend lawsuits, or for oversight of the originator of the notes. ***(Note: only required if applicable to your practice.)***

Other. Other uses and disclosures of your health information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our privacy officer and we will no longer disclose

health information under the authorization. But a disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding health information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy health information that may be used for your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to _____. We have up to 30 days to make your health information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your health information is maintained in an electronic format such as an electronic medical record, you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your health information in the format you request, if it is readily producible in such format. If the health information is not readily producible in the format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record, and any electronic media.

Right to Receive Notice of a Breach. We are required to have security and privacy safeguards to protect your health information. If there is a breach of those protections, we will notify you and others as the law requires.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment if the information is kept by or for our office. To request an amendment, you must make your request, in writing, to _____.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of health information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to _____.

Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to _____. In general, we are not required to agree to your request unless you pay out of pocket as described below.

Right to Restrict Health Plan Access When You Pay Out-of-Pocket. If you paid out-of-pocket in full for a specific health care item or service and requested that we not bill your health plan for a specific item or service, you have the right to ask that your health information with respect to that item or service not be disclosed to a health plan and we will honor that request, unless disclosure is required by another law. To request the same restriction on follow-up care, you must pay out of pocket and request the restriction on follow-up care.

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 by mail or at work. To request confidential communications, you must make your request, in writing, to _____. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to 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. You may obtain a copy of this notice at our web site, www.____. To obtain a paper copy of this notice, you may contact _____.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact _____. All complaints must be made in writing. **You will not be penalized for filing a complaint.**

Disclaimer:

- This is a model form. All parts of the form and all the examples in the form should be reviewed and adapted to address the specific needs of your practice. While all efforts have been made to ensure that the forms are current at the time they are posted, they are for educational purposes only and do not constitute legal advice. If your practice requires legal advice about complying with HIPAA, HITECH or Vermont laws, you should consult with an attorney.