# Notice of Privacy Practices

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

**Effective: April 1st, 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.

Memorial Health System, DBA Marietta Memorial and Selby General Hospitals and their respective physician offices, uses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Your health information is contained in a medical record that is the physical property of Memorial Health System.

**How We May Use and Disclose Medical Information About You**
**For Treatment:** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, or others who need to know about you to provide quality patient care. This information may be disclosed through information we record in your medical record or verbally between health care providers. We will also provide other medical facilities with information about you and your diagnoses which they will need in order to treat you.
**For Payment:** We may use and disclose medical information about you so that the treatment and services you receive may be billed and payment may be collected from you, an insurance company or a third party. For example, we may need to give your insurance company information about a procedure we performed so we can be paid for the office visit.
**For Health Care Operations:** We may use and disclose medical information about you for operational purposes. For example, your health information may be disclosed to members of our staff, risk or quality improvement personnel, and others to evaluate the performance of our staff, assess the quality of care, learn how to improve our office and services.
**Appointments.** We may use your information to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
**Fund Raising.** Memorial Health Foundation may use your information to contact you to raise funds for Memorial Health System and its health related activities. We would only release contact information such as your name, address and phone number and the dates you received treatment or services at the hospital. If you do not want the Foundation to contact you for fundraising efforts, you must notify the Memorial Health Foundation Office.

**Special Situations in Which Your Information May be Released**
**(including in response to Federal State or Local Law)**
- for judicial administrative proceedings pursuant to legal authority;
- to report information related to victims of abuse, neglect or domestic violence and to assist law enforcement officials in their law enforcement duties;
- if necessary to reduce or prevent a serious threat to your health or safety or the health or safety of another person or the public.
- in response to appropriate military authorities if you are a member of the military (including veterans)

**Local Public Health Authorities**
- in reporting child or elder abuse and neglect
- in reporting communicable diseases or your potential exposure to such
- in notifying you of recalls of drugs, products or devices you may be using

**Deceased Patients**
- to a medical examiner or coroner to assist in identifying the cause of death
- to allow funeral directors to do their jobs.

**Organ/Tissue donation.** Your health information may be used or disclosed for cadaveric organ, eye or tissue donation purposes.
**Workers' Compensation.** Your health information may be used or disclosed in order to comply with laws and regulations related to Workers' Compensation.

**We Will Always Get Your Written Authorization Before Releasing or Using Your Information:**
- for marketing purposes
- in a manner that would constitute the sale of your protected health information
- in a manner not described in this notice and where required by either Federal or State Law.

**Your Health Information Rights**
You have a right to:
- request a restriction on certain uses and disclosures of your information as provided by *45 CFR §164.522*. This may include a limit on medical information we disclose about you to someone who is involved in your care or payment for your care, such as a family member or friend. We are, however, not required to agree to a requested restriction except in cases where you have paid your bill in full and requested

a restriction on releasing your information to a group health plan, insurer, or other payor for purposes of payment or health care operations. You may request a restriction by completing a form developed by the office, or you can send a written request to the Health Information Services Department of Marietta Memorial Hospital.

- obtain a paper copy of this notice at any time from the front desk.
- inspect and obtain a paper copy of your health record and obtain an electronic copy to the extent the office utilizes an electronic medical record.
- amend your health record as provided in *45 CFR §164.526.* To request a copy or to amend your information you must make your request in writing and submit the request to the front desk or office address.
- request communications of your health information by alternative means or at alternative locations.
- revoke special authorizations to use or disclose health information for certain purposes except to the extent that action has already been taken.
- request an accounting of all disclosures of your health information when the disclosure has not been pursuant to treatment, payment, operations, or an authorization and, if your information is maintained in an electronic format, request an accounting of any disclosures dating back three years from the date of the request.
- request a hard copy of your medical information; or an electronic copy in a format requested by you if such format is readily producible.
- receive a written notification of any inappropriate release or use of your protected health information.

**Obligations of HouseCall Primary Care, PLLC**

We are required to:

- maintain the privacy of protected health information.
- provide you with this notice of our legal duties and privacy practices with respect to your health information.
- abide by the terms of this notice.
- notify you of certain breaches or the inappropriate release or use of your information.
- notify you if we are unable to agree to a requested restriction on how your information is to be used or disclosed.
- accommodate reasonable requests you may make to communicate health information by alternative means or at alternative locations.
- release the minimum amount of your information necessary to accomplish information related functions and de-identify your information to the extent practicable.
- obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

**Changes to This Notice**

We reserve the right to change our information practices and to make new provisions effective for all protected health information we maintain. At the end of this notice you will be asked to sign that you have received the notice and have had the opportunity to receive a copy. Your signature is requested to help us determine which version of the notice you have received. Revised notices will be posted in the office and in registration areas throughout Memorial Health System. A paper copy will be made available to you upon request.

If you have questions or complaints, please contact:

HouseCall Primary Care, PLLC
220 West Jackson Ave #106
Knoxville, TN 37902
(865) 330-7425

If you believe your privacy rights have been violated, you can file a complaint with the with the Department of Health and Human Services. There will be no retaliation for filing a complaint.

ACKNOWLEDGMENT

____________________________
DATE

____________________________
Signature of Patient

____________________________
Other Person Legally Authorized to Acknowledge

____________________________
Relationship to Patient