

## Notice of Privacy Practices

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

**IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE ASK TO SPEAK TO THE PRIVACY OFFICIAL, DAN FRANCIS AT 1-800-717-9410.**

Your medical information is personal. We are committed to protecting your medical information. We create a record of the care and services you receive at this office. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by this office whether made by your personal physician or one of the office's other employees.

This Notice will tell you about the ways in which we may use and disclose your medical information. This Notice will also describe your rights and certain obligations we have regarding the use and disclosure of your medical information.

This Company is required by law to:

- (1) make sure that medical information that identifies you is kept private;
- (2) give you this Notice of our legal duties and privacy practices with respect to medical information about you; and
- (3) Follow the terms of the Notice that is currently in effect.

### **How the Equity Health Plan, affiliated companies and organizations may use and disclose Your medical information**

The following describes the different ways that your medical information may be used or disclosed by the Equity Health Plan and affiliated companies and organizations. For clarification we have included some examples. Not every possible use or disclosure is specifically mentioned. However, all of the ways we are permitted to use or disclose your medical information will fit within one of these general categories:

**For Treatment.** We will use medical information about you to provide you with medical treatment and services referrals. We may disclose medical information about you to doctors, nurses, technicians and other office personnel who are involved in providing you medical treatment.

**For Payment.** We may use and disclose medical information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about treatment you received here so your health plan will pay us or reimburse you for the treatment. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover your treatment. We may also use your medical information to pay providers that you choose to deliver services to you.

**For Health Care Operations.** We may use and disclose medical information about you for Equity Health Plan operations. These uses and disclosures are necessary to run our office and make sure that all of our clients receive quality care. For example, we may use medical information to review your treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many of our patients to decide what additional services the Company should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to the Centers for Disease Control, doctors, nurses, technicians, and other office personnel for review and learning purposes. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning the identity of the specific patients.

**Appointment Reminders.** We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care scheduled by us.

**Treatment Alternatives.** We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

**Health-Related Benefits and Services.** We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

**Research.** Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another for the same condition.

**As Required By Law.** We will disclose medical information about you when required to do so by federal, state or local law. For example, disclosure may be required by Workers' Compensation statutes and various public health statutes in connection with required reporting of certain diseases, child abuse and neglect, domestic violence, adverse drug reactions, etc.

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

**Health Oversight Activities.** We may disclose medical information to a governmental or other oversight agency for activities authorized by law. For example, disclosures of your medical information may be made in connection with audits, investigations, inspections and license renewals, etc.

**Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may use your medical information to defend the office or to respond to a court order.

**Law Enforcement.** We may release medical information about you if required by law when asked to do so by a law enforcement official with or without a court order or warrant.

**Coroners and Medical Examiners.** We may release medical information to a coroner or medical examiner to identify a deceased person or to determine the cause of death.

#### **Your Rights Regarding Your Medical Information:**

You have the following rights regarding medical information this Company maintains about you:

**Right to Inspect and Copy.** You have the right to inspect and copy your medical information with the exception of any psychotherapy notes.

To inspect and copy your medical information, you must submit your request in writing. If you request a copy of the medical information, we do not charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain, very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed.

**Right to Amend.** If you feel that medical 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 this office.

To request an amendment, your request must be made in writing and submitted to Audrey Boyles. In addition, you must provide a reason that supports your request.

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 information that:

- (a) Was not created by us;
- (b) Is not part of the medical information kept by this office;
- (c) Is not part of the information which you would be permitted to inspect and copy;
- (d) Is accurate and complete.

**Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the

disclosures this office has made of your medical information.

To request an accounting of disclosures, you must submit your request in writing. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the use and disclosure we make of your medical information.

*We are not required to agree to your request for a restriction.* If we do agree, we will comply with your request unless the information is needed to provide emergency treatment.

To request restrictions, you must make your request in writing.

**Right to Request Confidential Communications.** You have the right to request that we communicate with you only in a certain manner. 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. We will accommodate all reasonable requests.

**Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

#### **Revisions to This Notice**

We reserve the right to revise this Notice. Any revised Notice will be effective for medical information we already have about you as well as information we receive in the future. We will post a copy of any revised Notice in this office. Any revised Notice will contain on the first page, in the top right hand corner, the effective date. In addition, each time you visit the office 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 this office and with the Secretary of the Department of Health and Human Services. To file a complaint with this office, contact Audrey Boyles, Practice Manager at 248-280-8550. All complaints must be submitted in writing.

THIS COMPANY WILL NOT PENALIZE YOU IN ANY WAY FOR FILING A COMPLAINT.

#### **Other Uses of Medical Information**

Other uses and disclosures of your medical information not covered by this Notice of Privacy Practices will be made only with your written authorization. If you provide us such an authorization in writing to disclose medical 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 medical information about you for the reasons covered by your written authorization.

**I have received a copy of this statement, I understand and accept these terms and conditions regarding the privacy of the medical information held by Equity health Plan and their parent company Medical Homes of America.**

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness signature

\_\_\_\_\_  
Date