



OAK MILL MEDICAL ASSOCIATES HIPAA Notice Of Privacy Practices Patient information authorization form 2013

Effective Date of Notice: January 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.

I. Our Commitment To Safeguard Your Health Information

a. Oak Mill Medical Associates (**OMMA**) is dedicated to maintaining the privacy of your protected health information. Protected health information is any form about your past, present or future health condition, the health care provided to you, or the past, present or future payment for your health care, and includes identifiers that do or could be used to identify you.

b. OMMA is required to maintain the privacy of your protected health information and to provide you with a copy of this Notice of Privacy Practices (Notice). This Notice describes our health information privacy practices, and other health care providers with whom we participate in order to conduct quality improvement, payment or operational activities.

c. OMMA reserves the right to change its privacy practices and the terms of this Notice at any time. In the event we materially change a privacy practice, the change will be effective for all information already maintained about you, and the revised Notice will be promptly posted. You may also request a copy of the Notice currently in effect from the **Office Administrator – Denise Alessi, CMA, CPC, CMM** or you may obtain a copy of the Notice from our website at www.oakmillmedical.com

II. How Your Protected Health Information May Be Used Or Disclosed

a. We have the right to use or disclose your protected health information for treatment, payment or health care operational activities, and under certain circumstances, the law may require us to disclose your protected health information. We may disclose your protected health information to a third party (business associates) to perform a function or service on behalf of OMMA, but before doing so, we will have a written agreement in place that extends the same privacy protection to your health information that we must apply. Business associates have a statutory obligation to comply with the terms of such agreements. Listed below are descriptions and examples of other uses or disclosures we may make of your protected health information.



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i. Disclosures Related To Treatment, Payment, Or Operational Activities:

1. Payment. OMMA may use or disclose your protected health information in connection with paying for, or providing, your health care treatment or running normal business operations. Payment and health care operations include disclosures to business associates that perform certain services for OMMA or act on behalf of, OMMA. Prior to any disclosure to a business associate, OMMA will obtain an appropriate agreement from the recipient of your information in order to restrict further redisclosure to the extent required by law.

2. Treatment alternatives. Your protected health information may be used to provide you with information about treatment alternatives.

3. Health-Related Benefits and Services. Your protected health information may be used to provide you information about other health-related benefits or services that may be of interest to you.

4. Minimum Necessary. When using or disclosing protected health information, we will limit the use, disclosure of request to a limited data set to the extent practicable or, if needed, to the minimum amount of protected health information necessary to accomplish its intended purpose(s). A limited data set is protected health information that excludes your direct identifiers (listed in 45 CFR §164.514(e)(2)) or those of your relatives, employers or household members. The minimum necessary standard will not apply in the following situations:

- a. Disclosures to or requests by healthcare provider for treatment;
- b. Uses or disclosures made to you;
- c. Uses or disclosures made pursuant to your authorization;
- d. Disclosures made to the Secretary of the U.S. Department of Health and Human Services;
- e. Uses or disclosures that are required by law; and
- f. Uses or disclosures that are required for our compliance with legal regulations.

ii. Other Uses Or disclosures Of Your Protected Health Information

1. Required by Law. Your protected health information may be disclosed when the use or disclosure is required by law.

2. Public Health Activities. Your protected health information may be disclosed for public health activities. For example, your protected health information may be disclosed to prevent or control disease, injury or disability; report child abuse or neglect; maintain vital records, such as births and deaths; notify a person regarding potential exposure to a communicable disease; notify a person regarding a potential risk for spreading or contracting a disease or condition; notify an appropriate government agency about the abuse or neglect of an adult individual (including domestic violence); or to the federal Food and Drug Administration (FDA) to report adverse events with medications; track regulated products, report product recalls, defects or replacements.



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3. Abuse, Neglect, and Domestic Violence. If we reasonably believe you are a victim of abuse, neglect or domestic violence, to the extent the law requires, protected health information about you may be disclosed to an agency authorized by law to receive such reports.

4. Judicial and Administrative Proceedings. We may disclose your protected health information in the course of any judicial or administrative proceeding. For example, we may disclose your protected health information in response to a court or administrative order, or in response to a discovery request, subpoena or other lawful process.

5. To Avert A Serious Threat To Health Or Safety. Your protected health information may be disclosed to reduce or prevent a serious threat to your health and safety or the health and safety of the public or another person. For example, to prevent or control disease; maintain vital records, such as births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify a person regarding potential exposure to a communicable disease; notify people of recalls of products they may be using; in response to a warrant, summons, court order, subpoena or similar legal process; identify/locate a suspect, material witness, fugitive or missing person; or in an emergency, to report a crime or the description, identify or location of the perpetrator.

6. Workers' Compensation. Your protected health information may be disclosed for workers' compensation or similar programs in order for you to obtain benefits for work-related injuries or illness.

III. Your Rights Related To Your Protected Health Information.

a. Right to Inspect And Copy. You have the right to inspect and obtain a copy of your private health information included in a designated record set for a period of six years or as required by state law. You may be charged a fee for the cost of copying, mailing, labor and supplies associated with your request. To inspect and copy the information you must submit your request in writing to the **Office Administrator, Denise Alessi, CMA, CPC, CMM.**

b. Right to Amend. You have the right to request OMMA to amend your health information that it maintains in a designated record set if you believe it is inaccurate or incomplete. OMMA may deny your request for an amendment if it believes your information is accurate and complete, or if the information was created by a party other than OMMA.

c. Right to an Accounting of Disclosures. You have the right to request a list of those instances where your protected health information has been disclosed by us other than disclosures:

i) for treatment, payment or operational activities; **ii)** to you or as authorized by you; **iii)** for national security or intelligence activities; **iv)** to correctional institutions or law enforcement officials; or **v)** incident to a disclosure we are required to make. To obtain an accounting of disclosures, you must submit your request in writing to the **Office Administrator – Denise Alessi, CMA, CPC, CMM.** If you request more than one accounting within a 12-month period, we will charge a reasonable, cost-based fee for each accounting after the first one.



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d. Right to Request Restrictions. You have the right to request, in writing, further restrictions on the way your private health information is used or shared with others. In most cases OMMA is not required to agree to the restriction you request, but if it does, it will be bound by the agreement.

e. Right to Request Confidential Communications. You have the right to request that we communicate with you about your health and health related issues in a particular manner or at a certain location. For instance, you may ask to be contacted by mail rather than by telephone, or at home rather than work. In order to request a type of confidential communication, you must submit a request in writing to the **Office Administrator – Denise Alessi, CMA, CPC, CMM**. Your request must specify the alternate method of contact you are requesting or the location where you wish to be contacted. You do not need to give a reason for your request. We will accommodate reasonable requests.

f. Right to a Paper copy of This Notice. You are entitled to receive a paper copy of this Notice at any time by contacting the **Office Administrator – Denise Alessi, CMA, CPC, CMM**. You may also obtain a copy from the website www.oakmillmedical.com.

g. Right to File a Complaint. If you are concerned that your privacy rights may have been violated, you may file a complaint with the Office Administrator or the Secretary of the Department of Health and Human Services' Office of Civil Rights. You will not be retaliated against for filing a complaint.

h. Right to Receive Notice of Breach. We are required to notify you if your protected health information has been breached. This notification must occur by regular mail no later than 60 days after we discover the breach. If the breach involves more than 500 residents of any state or region we may also have to notify prominent local media outlets or the Secretary of the Department of Health and Human Services. A breach occurs when there has been an unauthorized use or disclosure under the Health and Insurance Portability and Accountability Act of 1996 (HIPAA), that compromises the privacy or security of protected health information if it poses a significant risk for financial, reputational, or other harm to the individual.

The notice must:

- i. Contain a brief description of what happened, including the date of breach and the date of discovery;
- ii. The steps an individual should take to protect themselves from potential harm resulting from the breach;
- iii. A brief description of what we are doing to investigate the breach, mitigate losses, and to protect against further breaches.

Not every impermissible use or disclosure of private health information constitutes a reportable breach. The determination of whether an impermissible breach is reportable hinges on whether there is a significant risk of harm to the individual as a result of impermissible activity.



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IV. Other Uses of Protected Health Information

a. Authorization. Other uses and disclosures of medical information not covered by this Notice will be made only with your written authorization. You may revoke an authorization for the use or disclosure of your protected health information in writing at any time. Your request should be made in writing to the **Office Administrator – Denise Alessi, CMA, CPC, CMM**. If you revoke the authorization, your protected health information will no longer be used or disclosed for the reasons covered by your written authorization; however, the revocation will not apply to any disclosures already made with your authorization. To request confidential communications, you must make your request in writing to **Denise Alessi, CMA, CPC, CMM, Office Administrator**.

We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

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 will post a copy of the current notice in our facility. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register for treatment or health care services, 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 us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact **Denise Alessi, CMA, CPC, CMM, Office Administrator**. All complaints must be submitted in writing. You will not be penalized for filing a complaint.



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Acknowledgement of Receipt of Notice of Privacy Practices

I, _____ have received the Notice of Privacy Practices from Oak Mill Medical Associates.

X, _____ Date: _____

In lieu of patient signature, I, _____, a staff member of Oak Mill Medical Associates, state that _____ has been given our current Notice of Privacy Practices.

X _____



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I authorize Oak Mill Medical and staff to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes.

Home Telephone	_____	YES	_____	NO
Answering Machine	_____	YES	_____	NO
Work Telephone	_____	YES	_____	NO
Voice Mail	_____	YES	_____	NO
Pager	_____	YES	_____	NO
Cell Phone/or Voice Mail	_____	YES	_____	NO
Designated Family Member	_____	YES	_____	NO
Fax Medical Records				
For referrals to another entity	_____	YES	_____	NO

Please list names of authorized people:

Spouse: _____ Telephone # _____ no _____

Parent: _____ Telephone # _____ no _____

Other names (please list relationship such as boyfriend, fiancé, girlfriend, sister, etc.)

Name: _____ Telephone # _____

Name: _____ Telephone # _____

Name: _____ Telephone # _____

Patient/Guardian Signature: _____

Date: _____