

Notice of Privacy Practices / James J. Dalla Riva OB/GYN

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.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical conditions being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of **DALLA RIVA OB/GYN**. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of Your Protected Health Information

Your protected health information will be used by **Dalla Riva OB/GYN** or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information.

Dalla Riva OB/GYN may or may not agree to restrict the use or disclosure of your protected health information.

If **Dalla Riva OB/GYN** agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices

Dalla Riva OB/GYN reserves the right to modify the privacy practices outlined

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

Fund raising. Unless you request us not to, we may use your name and address to support our fund raising efforts.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- the right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- the right to receive a printed copy of this notice

DALLA RIVA, OB/GYN Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting **OUR RECEPTIONIST** or our **OFFICE MANAGER**.

** For more information concerning our privacy practices; contact our Office Manager, Karen L. Copeland, CPC*

Dr. Dalla Riva and Dr. Hulsen OB/GYN
PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

Patient Name: _____

Date of Birth: _____

_____ (Patient/Representative initials) **Notice of Privacy Practices.**

I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

_____ (Patient/Representative initials) **Release of Information.**

I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior admission(s) at other HCA affiliated facilities may be made available to subsequent HCA-affiliated admitting facilities to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?"

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Consent for Photographing or Other Recording for Security and/or Health Care Operations

____ (Patient/Representative Initials) ***I consent*** to photographs, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used without a specific written authorization from me or my legal representative unless it is for treatment, payment or health care operations purposes or otherwise permitted or required by law.

____ (Patient/Representative Initials) ***I do not consent*** to photographs, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities).

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:

We want to stay connected with our patients.

Patients in our practice may be contacted via email and/or text messaging to confirm an appointment, to obtain feedback on your experience with our healthcare team, and to be provided general health reminders/information. If at any time, you provide an email address or text number below, you understand that you may get these communications from the Practice. You may opt out of these communications at any time. The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is _____.

The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is _____.

OR

____ (Patient/ Representative Initials) I decline to receive communication via text.

____ (Patient/ Representative Initials) I decline to receive communication via email.

If you have previously consented to receive communication via text/email and wish to remove the consent

Opt Out/Revocation of communications via email and/or text. In other words, I do not want my email address or cell number to be used any longer for the above mentioned communications.

___ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via **text**.

___ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via **email**.

Patient Name: _____

Patient/Patient Representative Signature: _____

Date: _____ Time: _____

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

____ (Patient/Representative Initials) I ***wish*** to designate the following individual to pick up a prescription order on my behalf:

Name: _____ Date: _____

Name: _____ Date: _____

____ (Patient/ Representative Initials) I ***do not want*** to designate anyone to pick-up my prescription order.

Patient/Parent/Guardian/Patient Representative Signature _____ Date: _____

Patient/Parent/Guardian/Patient Representative Name (Printed) _____

Patient Name (Printed): _____ Date of Birth: _____

7.0 Patients' Rights Policy

The Practice recognizes that Patients are afforded the following Rights under HIPAA and will abide by all applicable requirements regarding these Rights:

- To see and receive a copy of the Patient's health records, known as a "designated record set", under HIPAA (Access) and to receive it electronically if the Practice maintains it in electronic form;
- To direct the Practice to send the Patient's information to a third party, so long as the request is in writing, is signed by the Patient, and clearly designates to whom the Patient wants his/her information sent. (See form 7.0c Request to Send Patient Information Directly to a Third Party)
- To have corrections added to the Patient's health information (form 7.0j Request for Amendment of PHI);
- To be notified of a breach of the Patient's unsecured PHI;
- To request reasonable restrictions on the use and disclosure of the Patient's PHI for treatment, payment or health care operations of the Practice (form 7.0d Request for Restriction on Uses/Disclosures of PHI) and to reasonably request to receive communications of PHI from the Practice by alternative means or at alternative locations;
- To receive a notice informing the Patient how their health information may be used and shared by the Practice (form 3.8a Notice of Privacy Practices for PHI);
- To decide if the Patient would like to give permission before his/her health information may be used or shared for certain purposes, such as for marketing and sale of PHI (form 7.0b Authorization for Certain Uses and Disclosures of PHI);
- To receive a report on when and why the Patient's health information was shared for certain purposes (form 7.0i Request for Accounting of Disclosures of PHI);
- To request that the Practice not share information with the Patient's insurance company if the Patient pays for the item or service out-of-pocket and in full at the time of service;
- To file a complaint with the Practice or with the federal government if the Patient (or any other individual) believes that his or her Rights are being denied or his or her health information is not being protected.

In order to exercise a Patient Right under HIPAA, the Practice will require that the Patient's request be submitted in writing to the Privacy Officer. The Practice's standard forms for these Rights may be utilized by the Patient in requesting a Right; however, other written requests that are submitted, including via email, will be honored, if they include all required elements under the HIPAA Rules.

If a Patient exercises a Right under HIPAA, the Practice will abide by all required response timelines.

All documentation of compliance with Patient's Rights will be maintained by the Practice for a period of at least 6 years.

7.0a Authorization Form

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) states that the Practice cannot share your Protected Health Information (PHI) without your permission, except in certain situations. For example, your PHI can be shared without your permission if it is used to facilitate your healthcare treatment, payment, or for healthcare operations. By signing this form, you are giving us permission to share your PHI as you indicate below.

I understand that my healthcare and the payment for my healthcare will not be affected by my signing this form. I understand that treatment, payment, enrollment or eligibility for benefits will not depend in any way on whether or not I sign this authorization. I further understand that I may inspect and copy any information disclosed pursuant to this authorization, and that I will receive a copy of this form upon signing it if the Practice is soliciting my signature.

I understand that if the organization authorized to receive the information is not a health plan or healthcare provider or other entity considered a covered entity under HIPAA, the released information may no longer be protected by federal privacy regulations. I further understand that information disclosed pursuant to this authorization may be re-disclosed by the parties listed below and no longer protected.

I understand that this authorization is voluntary and may be revoked at any time by signing the revocation section of my copy of this form and returning it to the Practice. I further understand that any such revocation does not apply to the extent that persons authorized to use and/or disclose my health information have already acted upon my previous authorization(s).

I hereby authorize the use and/or disclosure of my PHI as described below:

Patient Name: _____

Persons/Organization(s) to receive the information: _____

Specific description of information to be disclosed or used (include applicable dates): _____

The Practice of Dalla Riva OB/GYN

HIPAA Policies & Procedures

What is the purpose of the requested use or disclosure? *(The statement "at the request of the individual" is sufficient if the Patient initiates the authorization and does not wish to provide a further purpose.)*

Expiration of authorization: (You must specify a date or event, i.e. at the end of litigation.)

Patient Signature & Date

REVOCATION SECTION:

I hereby revoke this authorization, effective ____/____/____.

Patient Signature

Date

Printed Name of Patient

Signature of Practice Privacy Officer

Date

If the Practice is seeking this authorization from you for a use or disclosure of your PHI, we will provide you with a copy of this signed authorization.

The Practice of Dalla Riva OB/GYN

HIPAA Policies & Procedures

7.0g Privacy Rights Complaint Form

The Health Insurance Portability and Accountability Act of 1996 requires that the Practice protect the privacy of your PHI (PHI). If you are concerned that we have violated (a) your privacy rights, or (b) our policies and procedures implementing HIPAA compliance within the Practice, and/or you disagree with a decision we made about access to, or amendment of, your records, you may contact the Practice's Privacy Officer.

You also have the right to file a complaint with the Office for Civil Rights, Secretary of the Department of Health and Human Services (HHS). Directions for this process may be found at:
www.hhs.gov/ocr/privacy/hipaa/complaints.

We will not retaliate against you for filing a complaint with the Practice or with the Secretary of HHS.

The Practice will investigate reported violations of any privacy policy and will develop and implement a corrective plan of action to deal with any discovered violations.

Please provide the following information so that we may properly address your complaint:

Details of your complaint: (Please be as specific as possible with respect to dates and times; include the name(s), if any, of anyone in the Practice with whom you discussed your complaint. Use the other side of this form if you need more space.)

Patient Signature

Date