

Notice of Privacy Practices

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

I. WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

We are legally required to protect the privacy of your health information. We call protected health information, or PHI for short, and it includes information that can be used to identify you that we've created or received about your past, present, or future health or condition, the provision of health care to you, or payment of this health care. We must provide you with this notice about our privacy practice that explains how, when, and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this section.

However, we reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the PHI we already have. Before we make an important change to our policies, we will promptly change this notice and post a new notice in the main reception area of our office. You can also request a copy of this notice from the contact person listed in Section IV at any time.

II. HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION.

We use and disclose health information for many different reasons. For some of these uses or disclosures, we need your specific authorization. Below, we describe the different categories of our uses and discloses and give you some examples of each category.

A. We may use or disclose your PHI for the following reasons: treatment, payment and health care operations.

1. **For treatment.** We may disclose your PHI to physicians, nurses and other health care personnel who provide you with health care services or are involved in your care. For example, if you're being treated for a knee injury, we may disclose you PHI to the physical rehabilitation facility in order to coordinate your care.
2. **To obtain payment for treatment.** We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you. For example, we may provide your PHI to our business associates such as billing companies, claims processing companies, and others that process our health care claims.
3. **For health care operations.** We may disclose your PHI in order to operate this facility. For example, we may use your PHI in order to evaluate the quality of health care services that you received.

B. Certain uses and disclosures do not require your authorization. We may use and disclose your PHI without your authorization for the following reasons:

1. When a disclosure is required by federal, state, or local law, judicial or administrative proceedings, or law enforcement.
2. For public health activities.
3. For health oversight activities.
4. For research purposes.
5. To avoid harm.
6. For specific government functions.
7. For workers' compensation purposes.
8. Appointment reminder and health-related benefits or services.
9. For purpose of organ donation.

- C. **Uses and disclosures require you to have the opportunity to object.** We may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.
- D. **All other uses and disclosures require your prior written authorization.** In any other situation not described in Sections II A, B, and C above, we will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke that authorization in writing to stop any future uses and disclosures (to the extent that we haven't taken any action relying on the authorization).

III. **WHAT RIGHTS YOU HAVE REGARDING YOUR PHI**

You have the following rights with respect to your PHI:

- A. The right to request restrictions on certain uses and disclosures of protected health information. However, you may not limit the uses and disclosures that we are legally required or allowed to make.
- B. The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations. We must agree to your request so long as we can easily provide it in the format you requested.
- C. The right to inspect and see copies of your protected health information, but you must make the request in writing.
- D. The right to get a list of certain disclosures we have made.
- E. The right to correct or update your protected health information.
- F. The right to obtain a paper copy of this notice from us upon request.

IV. **PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.**

If you have any questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact: The Director of Operations, 9420 Key West Avenue, Suite 100, Rockville, MD 20850. Phone: 301.762.3740.

If you think we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed above. You also may send a written complaint to the Secretary of the Department of Health and Human Services:

Office of Civil Rights
200 Independence Avenue, S.W.
Washington, DC 20201
(202.619.0257)

We will take no retaliatory action against you if you file a complaint about our privacy practices.

**DOCTORS GROOVER
CHRISTIE & MERRITT**
R A D I O L O G I S T S

V. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on April 23, 2003

I have received the Notice of Privacy Practices and understand my rights contained in the notice. By way of my signature, I provide Drs. Groover Christie & Merritt with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

Patient's Name (Print)

Date

Patient's Signature

Authorized Facility Signature

Date