

## **HIPAA NOTICE OF PRIVACY PRACTICES ELDERCOM OF CLEAR LAKE, INC.**

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.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices including any revision of our notice at any time by contacting us.

Contact Person:	Toni Turner
Company:	ElderCom of Clear Lake, Inc.
Telephone:	(281) 642-2700
Address:	3027 Marina Bay Drive, Suite 110 One Harbour Square League City, TX 77573
Email:	toniturnerslp@yahoo.com

### **USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION**

Your protected health information may be used and disclosed by ElderCom of Clear Lake, Inc. and others outside of our office that are involved in your care and treatment for the purpose of providing healthcare services to you, to pay your health care bills, to support the operation of the ElderCom practice and any other use required by law.

**Treatment.** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your healthcare with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment.** Your protected health information will be used, as needed, to obtain payment for your healthcare services. For example, obtaining approval for treatment may require that your relevant protected health information be disclosed to the health plan to obtain approval for the treatment.

**Healthcare Operations.** We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of speech pathology students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your therapist. We may also call you by name in the waiting room when your therapist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose health information to notify or assist in the notification (including identifying or locating) a family member, your personal representative or another person responsible for your care or your location, your general condition or death. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Research, Criminal Activity, Military Activity and National Security, Worker's Compensation, Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization at any time in writing, except to the extent that your physician or the physician's practice has taken action in reliance on the use or disclosure indicated in the authorization.

#### YOUR RIGHTS

The following is a statement of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information.** You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form by using the contact information listed in this Notice. We will charge you reasonable cost based fees for expenses such as copies and staff time. You may also request access by sending us a letter to the address in this notice. If you request copies, we will charge you \$0.50 for each page, \$10.00 per hour for staff time to locate and copy your health information and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. In the case of a child custody issue, we will need a legal documentation stating that no information is to be released to the person to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

**You have the right to revoke.** You will have the right to revoke this Consent at any time by giving us a written notice of your revocation submitted to the Contact Person listed above. Please understand that this revocation of Consent will not affect any action we took in reliance on this Consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this Consent.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us.** Upon request, even if you have agreed to accept this notice alternatively ie. electronically.

**You may have the right to have your physician amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost based fee for responding to these additional requests.

**Complaints.** If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or to have us communicate with you by an alternative means or alternative locations, you may complain to us using the contact information provided herein. You also may submit a written complaint to the U. S. Department of Health and Human Services. We will provide you with the address to file your complaint with us or the S. S. Department of Health and Human Services **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **January 1, 2008.**

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We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Print Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Patient's Name: \_\_\_\_\_

Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_