SAMPLE NOTICE OF PRIVACY PRACTICES

Note: This form is not meant to encompass all the various ways in which any particular facility may use health information and should be specifically tailored to your organization. In addition, as with any form of this nature, the document should be reviewed and approved by legal counsel prior to implementation.

NOTICE OF PRIVACY PRACTICES

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

[Covered Entity] may record, transmit, or maintain, either on paper or electronically, personal information about you, your medical history and your healthcare treatment as part of providing you with healthcare services or in connection with a health fair or other screening.

This Notice of Privacy Practices ("Notice") describes how we may use and disclose such information, our obligations regarding the use and disclosure of your medical information, and your rights with respect to the use and disclosure of your medical information. This Notice is required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

OVERVIEW

We are legally required to protect the privacy of information that identifies you or could be used to identify you, and relates to your past, present or future physical or mental health condition(s) or the provision of past, present, or future healthcare services (including payment for those services). This information is called "protected health information" or "PHI" for short.

We are legally required to follow the privacy practices that are described in this Notice. We reserve the right to change our privacy policies and the terms of this Notice at any time. Before any important policy change goes into effect, we will change this Notice.

We will post a copy of this Notice in all our registration areas for public viewing **[*Optional*** and on our website at **_____]**. You may also request a copy of this Notice at any time by contacting **[Covered Entity]**'s **[Compliance Office]** at **[phone or email address, or both]**.

USE AND DISCLOSURE OF YOUR PHI BY [COVERED ENTITY]

[Covered Entity] may use or disclose your PHI to carry out its responsibilities as a healthcare provider. **[Covered Entity]** may use or disclose your PHI without your written authorization for the following reasons:

- **Treatment. [Covered Entity]** may disclose PHI to physicians, nurses, technicians, hospitals, medical students or other personnel who are involved with the administration of your care at **[Covered Entity]** or other locations.

- **Payment.** We may use and disclose PHI so that payment for the treatment and services you receive at **[Covered Entity]** or from other entities, such as an ambulance company, may be billed to and collected from you, or an insurance company or third party. We may also need to disclose this information to insurance companies to establish insurance eligibility benefits for you.

- **Healthcare Operations.** "Healthcare operations" at **[Covered Entity]** include activities related to improving quality of care, staff training, medical education, and business management.

- **Appointment Reminders, Information about Healthcare Related Benefits and Treatment Alternatives.** We may use and disclose medical information to contact you as a reminder that you have an appointment for a treatment or medical care at **[Covered Entity]** or to inform you of treatment alternatives or other healthcare services or benefits that we offer.

- ***[Optional]*** **Fundraising Activities.** We may contact you regarding our fundraising activities related to _____. If you do not wish to be contacted for our fundraising efforts, please notify us in writing to the address or email address provided below. You may opt out of receiving communications regarding our fundraising activities at any time.

- ***[Optional]*** **Research.** All research studies conducted at **[Covered Entity]** must be approved through a special review process to protect patient safety, welfare and confidentiality. Your medical information may be important to further research efforts and the development of new knowledge. Subject to the confidentiality provisions of state and federal law, we may use and disclose your PHI for qualified research purposes. On occasion, researchers may contact **[Covered Entity]** patients about participating in research studies. Enrollment in those studies can only occur after you have been informed about the study, had an opportunity to ask questions, and indicated your willingness to participate by signing a consent form.

- **As Required By Law.** We will disclose PHI when required to do so by federal or state law, including in response to a court or administrative order, subpoena, discovery request, warrant, summons or other lawful process. **[Covered Entity]** may also disclose PHI to law enforcement personnel or similar persons to avoid a serious threat to the health or safety of a person or the public.

In addition, **[Covered Entity]** may use your PHI without your written authorization under the following circumstances:

- Emergency situations when your authorization cannot be reasonably obtained, including for disaster relief purposes;
- To business associates (outside vendors or consultants that perform services on behalf of **[Covered Entity]** and are contractually required to appropriately safeguard your information);
- To other healthcare facilities where **[Covered Entity]** physicians and healthcare professionals have privileges or to physicians from other healthcare facilities who see patients at **[Covered Entity]**;
- With your agreement, to a family member, relative, close personal friend, or any other person you identify;
- To facilitate organ or tissue donation if you are an organ donor;
- In connection with workers' compensation claims;
- To report abuse, neglect, or domestic violence as required by state of federal law;
- For public health and health oversight activities, such as preventing or controlling disease or investigations; or
- To coroners, medical examiners, or funeral directors as necessary to carry out their duties.

Certain actions, such as most uses of disclosures of psychotherapy notes, the use and disclosure of PHI for marketing purposes, and disclosures that constitute a sale of PHI, will be made only with your written permission (authorization). Other uses or disclosures of PHI that are not covered by this Notice or applicable laws also will be made only with your written permission.

Massachusetts provides special privacy protections for particularly sensitive conditions or illnesses such as HIV/AIDS, mental health, and substance abuse. **[Covered Entity]** will disclose such information only in a manner that is consistent with these laws.

You may revoke your permission at any time by writing to **[_____]** at the address or email address below. Once you revoke your permission, we will stop using or disclosing such information for the reasons covered by your written authorization. However, we cannot take back any disclosures made with your permission. We will retain our records of the care provided to you as required by law.

YOUR RIGHTS REGARDING YOUR PHI

Although your medical information is the property of **[Covered Entity]**, you have certain rights regarding your PHI, including the right to:

- **Inspect and Copy.** With certain exceptions, you have the right to inspect or receive a copy of your medical information or both. We may charge a fee for these services. We may deny your request in certain limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed. Another licensed healthcare professional chosen by **[Covered Entity]** will review your request and our denial.

- **Request an Amendment.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend information that is kept by or for **[Covered Entity]**. We may deny your request if you ask us to amend information that (a) was not created by **[Covered Entity]**; (b) is not part of the medical information kept by or for **[Covered Entity]**; (c) is not medical information you are permitted to inspect or copy; or (d) is accurate and complete in the record.

- **Request an Accounting of Disclosures.** You may request a list of the disclosures we have made of PHI that were for purposes other than treatment, payment, healthcare operations and certain other purposes, or disclosures made with your written authorization within the last six (6) years. You may be charged a fee in connection with this request.

- **Restrict or Limit Use or Disclosure.** You may ask us to restrict or limit the use or disclosure of your PHI, including the disclosure of information to someone who is involved in your care or the payment for your care, like a family member or friend. Your request must state: (1) what information you want to limit; (2) whether you want to limit **[Covered Entity]**'s use, disclosure or both; and (3) to whom the limits apply, for example, disclosures to your spouse. We are not required to agree to your request, unless it relates to an item or service you paid for in full and out of pocket. In this case, you may request that we not share health information pertaining only to that product or service with your health plan for the purposes of carrying out payment or healthcare operations and we will comply with your request unless the information is needed to provide you emergency treatment or except as required by law.

- **Confidential Communications.** Generally, we will use the address, telephone number and, in some cases, the email address you give us to contact you. You may ask us to communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Notification in the Event of a Breach.** Consistent with federal and state laws, we will notify you in the event unsecured PHI is used or disclosed by an unauthorized individual.

All requests must be submitted in writing to the address below. Your request must be specific and be signed by you or an authorized representative.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint by writing to the address below or by calling the **[Covered Entity]** compliance hotline at **[_____]**. You may also file a complaint in writing with the Secretary of the U.S. Department of Health and Human Services in Washington, D.C. or through the regional office at J.F.K. Federal Building – Room 1874, Boston, MA 02203. The complaint must be filed within 180 days of the alleged violation. There will be no retaliation for filing a complaint.

CONTACT INFORMATION

If you have questions, would like to submit a written request, or need further assistance regarding this policy, please contact **[_____]** at:

[Address and Contact Information]

EFFECTIVE DATE

This Notice of Privacy Practices is effective **[DATE]**.