



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 CAREFULLY.

This notice takes effect on December 1, 2003 and remains in effect until replaced

1. MY PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important. I understand that your medical information is personal and I am committed to protecting it. I create a record of the care and services you receive at my office. I need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways I may use and share medical information about you. I also describe your rights and certain duties I have regarding the use and disclosure of medical information.

2. MY LEGAL DUTY

Law Requires That I:

1. Keep your medical information private.
2. Give you this notice describing my legal duties, privacy, practices, and your rights regarding your medical information
3. Follow the terms of the notice that is in effect.

I Have The Right To:

1. Change my privacy practices and the terms of this notice at any time, provided that the changes are lawful.
2. Make changes in my privacy practices and the new terms of my notice effective for all medical information that I keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before I make an important change in my privacy practices, I will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different way that we use the disclosure medical information. Not every use or disclosure will be listed. However, I have listed all of the different ways I am permitted to use and disclose information. I will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by written notice to me.

FOR TREATMENT: I may use your PHI for the purpose of providing you with health care treatment. To coordinate and manage your care, I may disclose your PHI to others of your current providers, and to the extent you have not raised an objection in writing, to your prior providers, or to other persons, including family members involved in your care.

FOR PAYMENT: I may use your PHI in connection with billing statements I send you and my system for tacking charges and credits to your account. In addition, but with your authorization, I may disclose your PHI to third party payers to obtain information concerning benefit eligibility, coverage, and remaining, availability, as well as to submit claims for payment to disclose PHI for medical necessity and utilization review purposes.

FOR HEALTH CARE OPERATIONS: I may use and disclose your PHI for the health care operations of my professional practice in support of the functions of treatment and payment. Such disclosures would be to Business Associates for health care education, or to provide planning, quality assurance, peer review, administrative, legal or financial services to assist me in my delivery of health care.

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ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment and health care operations, I may use and disclose medical information for the following purposes;

Notification: Medical information to notify or help notify; a family member, your personal representative or another person responsible for your care. I will share information about your location, general condition, or death. If you are present, I will get your permission if possible before I share, or give you the opportunity to refuse permission, In case of an emergency and if you are not able to give or refuse permission. I will share only the health information this is directly necessary for your health care, according to my professional judgment. I will also use my professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Research in Limited Circumstances: Medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Coroner, Medical Examiner, Funeral Director: I may disclose your personal information after your death to a coroner, funeral director, or organ transplant organization.

Specialized Government Functions: In some situations, I may disclose personal information of Armed Forces personnel to military authorities. I may disclose your medical information to an authorized federal official or other authorized person for purpose of national security, for providing protection to the President, or to conduct special investigations, as authorized by law. I may use or disclose your medical information to other government agencies that are providing you with benefits or services when the information is necessary for you to receive those benefits or services.

Court Orders, Judicial and Administrative Proceedings: Under certain circumstances, I may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process. Under limited circumstances such as a court order warrant or grand jury subpoena, I may share your information with a law enforcement official concerning the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution.

Public Health Activities: I may disclose medical information about you to public health agencies as provided by state and federal laws: (1) to prevent or control disease; (2) to report births or deaths; (3) to report child abuse or neglect to authorized agencies; (4) to report problems with medicines or products to the Food and Drug Administration (FDA); (5) to notify you if a product you are using is recalled; (6) to give notice of exposure to a disease or condition that is a health risk. Examples of these public health agencies are the Department of Health and the Department of Social and Health Services.

Health Oversight Activities: I may disclose medical information about you within the Health Care Authority and with agencies for oversight activities by law. Examples of these oversights activities include audits, inspections, investigation, and health professions licensing.

Victims of abuse, Neglect or Domestic Violence: I may disclose medical information to appropriate authorities if I reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. I may share medical information when necessary to help law enforcement officials capture a person who is admitted to being part of a crime or has escaped from legal custody.

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Workers Compensation: I may disclose medical information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.

Law Enforcement: Under certain circumstances, I may disclose medical information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

4. YOUR INDIVIDUAL RIGHTS

You Have Additional Rights Regarding Your Information:

1. You may review the health information I have about you. You may ask for a copy of it. I may charge a fee for copies. Under federal law, however, you may not review and copy psychotherapy notes or information compiled in reasonable anticipation of, or for use in a civil, criminal, or administration action or proceeding; or information that I cannot legally disclose to you, or information that I determine should not be disclosed to you because it might harm you or some else.
2. You have a right to receive an accounting of disclosures of your medical information I have made after December 1, 2003 for purposes other than disclosures for treatment, payment or health care operations and other specified exceptions.
3. Request that I place additional restrictions on my use or disclosure of your medical information. I am not required to agree to these additional restrictions, but if I do, I will abide by our agreement (except in the case of an emergency or where prohibited by law).
4. You may ask me to send your medical information to you by alternative means or to an alternative location. I will accommodate any reasonable request clearly stating that disclosure of all or part of the information could endanger you. If the request does not state that, I will consider request but may not accommodate it.
5. You may ask me to amend your medical information. You must make the request in writing, telling what information you want changed and why it should be changed. I am not required to make the changes you request. For Example, I am not required to change information I did not create or information that is correct. If I do not make the change to your request, I will tell you why. If I do make the changes, I will make a reasonable effort to inform others to whom I gave the information or who you tell me received the information.

QUESTIONS AND COMPLAINTS

You may contact me or the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated. All complaints must be submitted in writing. No retaliatory actions will be taken against you for filing a complaint.

Other uses of Medical Information: Other uses and disclosures of medical information not covered by this Notice or the laws that apply to me will be made only with your authorization. If you provide me with permission to use or disclose medical information about you by signing a written authorization, you may revoke that permission, in writing, at any time. If you revoke your permission, I will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that I am unable to take back any disclosures I have already made with your permission.

I am my own Privacy Officer: So, if you have any questions about this Notice of Privacy Practices, please contact me.

**1800 Cooper Pt Rd SW #18
Olympia, WA 98502
(360) 352-1668
(360) 352-1350 Fax**

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ACKNOWLEDGEMENT FORM

I have received the **Notice of Privacy Practices** and I have been provided an opportunity to review it and ask questions.

Name _____ Birth date _____

Signature _____

Date _____

Reviewed by legal counsel 12/05