

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

This practice uses and discloses health information about you for treatment, payment for treatment, administrative purposes, and to evaluate the quality of care that you receive. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing, to stop future uses and disclosures.

Treatment, Payment and Healthcare Operations

We use and disclose health information about you for treatment, payment, and healthcare operations.

- **Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you, or to family and friends you approve.
- **Payment:** We may use and disclose your health information to obtain payment for services we provide to you.
- **Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing.

Disclosure That Can Be Made Without Your Authorization

We may use or disclose your health information when we are required to do so by law or national security.

- **Public Health and Health Oversight:** We may disclose your medical information for public health activities mandated by federal, state, or local government, and if authorized by law, to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition, to report reactions to medications, problems with products or to notify people of recalls of products they may be using.
- **Abuse or Neglect:** We may disclose your health information to appropriate authorities when we suspect abuse or neglect. We may also disclose medical information to a public agency authorized to receive reports of child abuse or neglect, and to report abuse or neglect of elders or the disabled.
- **Legal Proceedings and Law Enforcement:** We may disclose your medical information in the course of judicial and administrative proceedings in response to an order of the court or other appropriate legal process, such as warrant or subpoena. We may also release information if we believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.
- **Worker's Compensation:** We may disclose your medical information as required by the Texas Worker's Compensation law.
- **Correctional Institution:** If you are an inmate or under the custody of law enforcement, we may release your medical information to the correction institution or law enforcement official.
- **Military, National Security, Intelligence Activities and Protection of the President:** We may disclose your medical information for specialized governmental functions such as military service, authorized national security and intelligence activities, and for protective services for the President of the United States, other authorized government officials, or foreign heads of state.
- **Research :** When a research projects and its privacy protections have been approved by an Institutional Review Board or privacy board, we may release medical information to researchers for research purposes.
- **Organ Donation, Coroners, Medical Examiners, and Funeral Directors:** We may release medical information to organ procurement organizations, to a coroner or medical examiner, or to a funeral director where such a discloser is necessary for the organizations to carry out their duties.

Your Rights Under the Federal Privacy Regulations

The United States Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPPA). Those regulations create several privileges that patients may exercise. We will not retaliate against a patient that exercises their HIPPA rights. You may give us written authorization to use your health information or to disclose it to anyone for any purpose. You also have the right to request restrictions on disclosure of PHI (Personal Health Information), or alternative means of communication to ensure privacy.

- **Request Restrictions:** You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or healthcare operations. We do NOT have to agree to this restriction, but if we do agree, we will comply with your request except under emergency circumstances. To request a restriction, submit the following in writing; (a) The information to be restricted, (b) what kind of restriction you are

requesting (i.e. on the use of information, disclosure of information or both), and (c) to whom the limits apply. Please send the request to the address and person listed below. You may also request that we limit disclosure to family members, other relatives, or close personal friends that may not be involved in your care.

- **Receiving Confidential Communications by Alternate Means:** You may request we send communications of protected health information by alternative means or to an alternative location. This request must be made in writing to the person listed below. We are required to accommodate only *reasonable* requests. Please specify in your correspondence exactly how you want us to communicate with you and, if you are directing us to send it to a particular place, the contact/address information.
- **Inspection and Copies of Protected Health Information:** You may inspect and/or copy health information that is within the designated record set. Texas law required that requests for copies be made in writing and we ask that requests for inspection of your health information also be made in writing. Please send your request to the person listed below. We can refuse to provide some information you ask to inspect or ask to be copied if the information includes psychotherapy notes, the identity of the person who provided information if it was obtained confidentially, is subject to the Clinical Laboratory Improvements Amendments of 1988, or has been compiled in anticipation of litigation. We can refuse to provide access to or copies of some information for other reasons, provided that we provide a review of our decision by another licensed health care provider who was not involved in the prior decision to deny access. Texas law requires that we are ready to provide copies or a narrative within 15 days of your request. We will inform you of when the records are ready or if we believe access should be limited. HIPPA permits us to charge a reasonable cost based fee. The Texas State Board of Medical Examiners (TSBME) has set limits on fees for copies of medical records that under some circumstances may be lower than the charges permitted by HIPPA. In any event, the *lower* fee will be charged.
- **Amendment of Medical Information:** You may request an amendment of your medical information in the designated record set. Any such request must be made in writing to the person listed below. We will respond within 60 days of your request. We may refuse to allow an amendment if the information wasn't created by the practitioners in this practice, is not part of the Designated Record Set, is not available for inspection because of an appropriate denial, or if the information is accurate and complete. Even if we refuse to allow an amendment you are permitted to include a patient statement about the information at issue in your medical record. If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we now have the correct information.
- **Accounting of Certain Disclosures:** You may request for us to provide an accounting of disclosures that are other than for treatment, payment, health care operation, or made via an authorization signed by you or you representative. Please submit any request for an accounting to the person listed below. If there is a charge we will notify you and you may choose to withdraw or modify your request *before* any costs are incurred.
- **Appointment Reminders, Treatment Alternatives, and Other Health-Related Benefits:** We may contact you by telephone or mail to provide appointment reminders, information about treatment alternatives, or health-related benefits and services that may be of interest to you.

Our Promise to You

We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

Questions, Complaints and Contact Information

- If you are concerned that your privacy rights have been violated you may contact the person listed below. You may also send a written complaint to the United States Department of Health and Human Services. The contact information for the United States Department of Health and Human Services is:
 - U.S. Department of Health and Human Services
 - HIPPA Complaint
 - 7500 Security Blvd., C5-24-04
 - Baltimore, MD 21244
- If you have any questions or want to make a request pursuant to the rights described above, please contact:
 - Allyson Chheng
 - 4601 Old Shepard Place, Suite 201
 - Plano, Texas 75093
 - Phone (496)361-4000 Fax (469)361-4001

This notice is effective on the following date: 10/01/2008

We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen.

Acknowledgement of Review of
Notice of Privacy Practices for Willowbend Health & Wellness

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient or Personal Representative

Name of Patient or Personal Representative (Please Print)

Description of Person Representative's Authority

Date