# PRIVACY NOTICE

**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 Privacy Notice is being provided to you as a requirement of a federal law, the Health Insurance Portability and Accountability Act (HIPAA). This Privacy Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information in some cases. Your "protected health information" means any written and oral health information about you, including demographic data that can be used to identify you. This is health information that is created or received by your health care provider, and that relates to your past, present or future physical or mental health or condition.**

## I. Uses and Disclosures of Protected Health Information

***PIEDMONT WEST AMBULATORY SURGERY CENTER*** may use your protected health information for purposes of providing treatment, obtaining payment for treatment, and conducting health care operations. Your protected health information may be used or disclosed only for these purposes unless ***PIEDMONT WEST AMBULATORY SURGERY CENTER*** has obtained your authorization or the use or disclosure is otherwise permitted by the HIPAA privacy regulations or state law. Disclosures of your protected health information for the purposes described in this Privacy Notice may be made in writing, orally, or by facsimile.

A. **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 health care with a third party for treatment purposes. For example, we may disclose your protected health information to a laboratory, pharmacy or treating physicians.
B. **Payment.** Your protected health information will be used, as needed, to obtain payment for the services that we provide. This may include certain communications to your health insurance company to get approval for the service or procedure that we have scheduled (i.e. pre authorization or prior approval). We may also disclose protected health information to your health insurance company to determine your eligibility for benefits or whether a particular service is covered under your plan or to demonstrate medical necessity of the services or as required by your insurance company, for utililization review. We may also disclose protected health information to another provider involved in your care for the other provider's payment activities. This may include disclosure of demographic information to anesthesia or pharmacy care providers.
C. **Operations.** We may use or disclose your protected health information, as necessary for our own health care operations to facilitate the function of center and to provide quality care to all patients. Health care operations include such activities as: quality assessment and improvement activities, employee review activities, post up operative patient assessment, training programs including those in which students, trainees, or practitioners in health care learn under supervision, accreditation, certification, licensure or credentialing activities, review and auditing, including compliance reviews, medical reviews, legal services and maintaining compliance programs, and business management and general administrative activities.
D. **Other Uses and Disclosures.** As part of your treatment, payment and health care operations, we may also use or disclose your protected health information for the following purposes: to remind you of your appointment date, provide pre op instructions, provide post-op instructions, and discuss financial arrangements.

## II. Uses and Disclosures Beyond Treatment, Payment, and Health Care Operations Permitted Without Authorization or Opportunity to Object.

Federal privacy rules allow us to use or disclose your protected health information without your permission or authorization for a number of reasons including the following:

A. **When Legally Required.** We will disclose your protected health information when we are required to do so by any federal, state or local law.
B. **When There Are Risks to Public Health.** We may disclose your protected health information for the following public activities and purposes:

- To prevent, control, or report disease, injury or disability as permitted by law.
- To report vital events such as birth or death as permitted by or required by law.
- To conduct public health surveillance, investigations and interventions as permitted or required by law.
- To collect or report adverse events and product defects, track FDA regulated products, enable product recalls, repairs or replacements to the FDA and to conduct post marketing surveillance
- To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading as disease as authorized by law
- To report to an employer information about an individual who is a member of the workforce as legally permitted or required.

C. **To Report Suspected Abuse, Neglect or Domestic Violence.** We may notify government authorities if we believe that a patient is the victim of abuse, neglect or domestic violence when specifically required or authorized by law or when the patient agrees to the disclosure.
D. **To Conduct Health Oversight Activities.** We may disclose your protected health information to a health oversight agency for activities including audits; civil, administrative, or criminal investigations, proceedings, or actions; inspections; licensure or disciplinary actions; or

other activities necessary for appropriate oversight as authorized by law. We will not disclose your health information under this authority if you are the subject of an investigation and your health information is not directly related to your receipt of healthcare or public benefits.

E. **In Connection With Judicial And Administrative Proceedings.** We may disclose your protected health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order. In certain circumstances, we disclose your protected health information in response to a subpoena to the extent authorized by state law if we receive satisfactory assurances that you have been notified of the request or that an effort was made to secure a protective order.

F. **For Law Enforcement Purposes.** We may disclose your protected health information to a law enforcement official for law enforcement purposes as follows:

- As required by law for reporting of certain types of wounds or other physical injuries
- Pursuant to court order, court-ordered warrant, subpoena, summons or similar process
- For the purpose of identifying or locating a suspect, fugitive, material witness or missing person.
- Under certain limited circumstances, when you are the victim of a crime.
- To a law enforcement official if, the facility has a suspicion that your health condition was the result of a crime.
- In an emergency to report a crime.

G. **To Coroners, Funeral Directors, and for Organ Donation.** We may disclose protected health information to a coroner or medical examiner for identification purposes, to determine cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties.

H. **For Research Purposes.** We may use or disclose your protected health information for research when the use or disclosure for research has been approved by an institutional review board that has reviewed the research proposal and research protocols to address the privacy of your protected health information.

I. **In the Event of a Serious Threat to Health or Safety.** We may, consistent with applicable law and ethical standards of conduct, sue or disclose your protected health information if we believe, in good faith that such use or disclosure is necessary to prevent or lessen a serious and imminent threat to your health and safety or to the health and safety of the public.

J. **For Specified Government Functions.** In certain circumstances, federal regulations authorize the facility to use or disclose your protected health information to facilitate specified government functions relating to military and veterans activities, national security and intelligence activities, protective services for the President and others, medical suitability determinations, correctional institutions, and law enforcement custodial situations.

K. **For Worker's Compensation.** The facility may release your health information to comply with worker's compensation laws or similar programs.

## III. Uses and Disclosures Permitted without Authorization with Opportunity to Object

We may disclose your protected health information to your family member or a close family friend if it is directly relevant to the person's involvement in your surgery or payment related to your surgery. We can also disclose your information in connection with trying to locate or notify family members or others involved in your care concerning your location, condition or death.

You may object to these disclosures. If you do not object to these disclosures or we can infer from the circumstances that you do not object or we determine, in the exercise of our professional judgement, that it is in your best interests for us to make disclosure of information that is directly relevant to the person's involvement with your care, we may disclose your protected health information.

## IV. Uses and Disclosures which you Authorize

Other than as stated above, we will not disclose your health information other than with your written authorization. You may revoke your authorization in writing at any time except to the extent that we have action in reliance upon the authorization.

## V. Your Rights

You have the following rights regarding your health information:

A. **The right to inspect and copy your protected health information.** You may inspect and obtain a copy of your protected health information that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the facility use for making decisions about you.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to a law that prohibits access to protected health information.

Depending on the circumstances, you may have the right to have a decision to deny access reviewed. We may deny your request to inspect or copy your protected health information if, in our professional judgement, we determine that the access requested is likely to endanger your life or safety or that of another person, or that it is likely to cause substantial harm to another person referenced with the information. You have the right to request a review of this decision.

To inspect and copy your medical information, you must submit a written request to the Privacy Officer whose contact information is list on the last page of this Privacy Notice. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing or other costs incurred by us in complying with your request. These costs will be made known to you at the time of your request.

Please contact our Privacy Officer if you have questions about access to your medical record.

B. **The right to request a restriction on uses and disclosures of your protected health information.** You may ask us not to use or disclose certain parts of your protected health information for the purposes of treatment, payment or health care operations You may also request that we not disclose your health information to family members or friends who may be involved in your care or for notification purposes as described in this Privacy Notice. Your request must state the specific restriction requested and to whom you want the restriction to apply.

The facility is not required to agree to a restriction that you may request. We will notify you if we deny your request to a restriction. If the facility does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. Under certain circumstances, we may terminate our agreement to a restriction. You may request a restriction by contacting the Privacy Officer.

C. **The right to request to receive confidential communications from us by alternative means or at an alternative location.** You have the right to request that we communicate with you in certain ways. We will accommodate reasonable requests. We may condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not require you to provide an explanation for your request. Your request must be made in writing to our Privacy Officer.

D. **The right to request amendments to your protected health information.** You may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. 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. Requests for amendment must be in writing and must be directed to our Privacy Official. In this written request, you must also provide a reason to support the requested amendments.

E. **The right to receive an accounting.** You have the right to request an accounting of certain disclosures of your protected health information made by the facility. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Privacy Notice. We are also not required to account for disclosures that you requested, disclosures that you agreed to by signing an authorization form, disclosures for a facility directory, to friends or family members involved in your care, or certain other disclosures we are permitted to make without your authorization. The request must be made in writing to our Privacy Officer. The request should specify the time period sought for the accounting. We are not required to provide an accounting for disclosures that take place prior to April 14, 2003. Accounting requests may not be made for periods of time in excess of six years. We will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee.

F. **The right to obtain a copy of this notice.** Upon request, we will provide a separate paper copy of this notice even if you have already received a copy of the notice.

## VI. Our Duties

***PIEDMONT SURGERY CENTER*** is required by law to maintain the privacy of your health information and to provide you with this Privacy Notice of our duties and privacy practices. We are required to abide by terms of this Notice as may be amended from time to time. We reserve the right to change the terms of this Notice and to make the new Notice. If ***PIEDMONT WEST AMBULATORY SURGERY CENTER*** changes its Notice, we will provide a copy of the revised Notice by sending a copy of the revised Notice via regular mail or through in-person contact.

## VII. Complaints

You have the right to express complaints to ***PIEDMONT WEST AMBULATORY SURGERY CENTER*** and to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You may complain to the facility by contacting the Privacy Officer verbally or in writing, using the contact information below. We encourage you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

## VIII. Contact Person

This facility's contact person for all issues regarding patient privacy and your rights under the federal privacy standards is the Privacy Officer. Information regarding matters covered by this Notice can be requested by contacting the Privacy Officer. If you feel that your privacy rights have been violated by this facility, you may submit a complaint to our Privacy Officer by sending it to:

***PIEDMONT WEST AMBULATORY SURGERY CENTER***
**1800 Howell Mill Rd., Suite 250**
**Atlanta, Georgia 30318**
**404-537-4910**
ATTN: Privacy Officer
**The Privacy Officer can be contacted by telephone at: 404-537-4910**

## IX. Effective Date

This Notice is effective *2/01/10*

**Patient Label**

**PRIVACY NOTICE ACKNOWLEDGEMENT**

I acknowledge that I have received a copy of the Privacy Notice for **Piedmont Surgery Center**.

Privacy Notice Revision Date: February 1, 2010

_____ _____

**Patient or Personal Representative Signature** **Date**

_____

**Personal Representative's Relation to Patient**

**ABOVE - Patient or Personal Representative Use Only**

**BELOW - ASC Use Only**

**DOCUMENTATION OF GOOD FAITH EFFORT**

The patient identified above was provided with a copy of the Provider's Privacy Notice on this date. A good faith effort has been made to obtain a written acknowledgement of the patient's receipt of the Privacy Notice. However, acknowledgement has not been obtained because:

- ❑ Patient refused to sign the Privacy Notice Acknowledgement
- ❑ Patient was unable to sign because:

  _____

- ❑ There was a medical emergency. Provider will attempt to obtain acknowledgement as soon as practical.
- ❑ Other reason, described below:

  _____

  _____

_____ _____

***Employee Name/Signature*** ***Date***