

TOMMY J. MORGAN, M.D.

## NOTICE OF PRIVACY PRACTICES

The Privacy Standards of the Health Insurance Portability and Accountability Act (HIPAA) set standards for protecting the privacy of your information. Your Protected Health Information (PHI) includes medical records, billing information, identifying data, and any "individually identified health information." This notice describes uses and disclosures we may make with your PHI and your rights regarding this information. Please read this notice carefully before signing the Receipt of Notice of Privacy Practices. We value your privacy and will be glad to answer any questions you may have as you read this notice. You may also find helpful information regarding health information laws from the U.S. Department of Health and Human Services at: <http://www.hhs.gov/ocr/privacy>.

### Basic Uses of Health Information:

- **Treatment:** We may disclose your PHI to in the process of providing treatment such as when we make a referral to another provider, contact a pharmacy regarding your medication, contact a laboratory regarding tests, or in other treatment situations.
- **Payment:** We may disclose your PHI in the process of seeking reimbursement for treatment as when we interact with an insurance company, determine eligibility for treatment, or in the unfortunate circumstance of our having to refer to a collection agency.
- **Health Care Operations:** We may disclose your PHI in the process of operating the practice and optimizing practice performance such as when we perform quality assessments or when the clinic contacts you with reminders for appointments.
- **Family, Friends, Caregivers:** We may disclose your PHI to family, friends, or caregivers who are directly involved in your care. Please specify with whom we communicate on the form, "Authorization to Release Information to Family, Friends, or Caregivers." You may use the same form to decline any communication with family, friends, or caregivers though we may need to make such contact if we feel that someone's safety is at risk.

### Additional Uses of Health Information:

In some situations, you may desire release(s) of your PHI beyond treatment, payment, health care operations, or coordinating with family, friends, and caretakers. You may authorize us to release your PHI with the form, "Authorization to Release Information to Third Parties." Please keep in mind that certain portions of your health information like Psychotherapy Notes have a greater degree of protection and may have restrictions for release by law.

### Involuntary Uses of Health Information:

If the following situations occur, we may disclose information even if you do not consent.

- **Abuse:** We may disclose abuse, exploitation, or neglect of an individual that is under 18-years-old, developmentally disabled, or elderly.
- **Homicidal thoughts:** We may disclose a credible threat to harm someone. Such disclosure may include contacting law enforcement or the individual(s) being threatened.
- **Suicidal Thoughts:** We may disclose a threat to harm yourself if I feel that you are a significant risk to yourself and you are refusing treatment needed to protect your safety. Such disclosure may include calling law enforcement.
- **Legal:** We may disclose your health information when required to do so by federal law, state law, local law, court order, administrative order, warrant, summons, subpoena, or as required by worker's compensation laws.

- **Public Health:** We may disclose your health information in the interest of public health. One example of this would be disclosure made to prevent the spreading of a communicable disease. Another example would be the discovery that a medication is defective or dangerous.
- **Oversight:** We may disclose your health information for legally-authorized oversight activities which may include inspections, investigations, audits, and/or licensure or disciplinary actions.

Your Protected Health Information (PHI) Rights:

- You may request restrictions on the disclosure of your PHI for treatment, payment, and healthcare operations. We will consider such requests.
- You may request restrictions on the access of your PHI to certain individuals. We will consider such requests.
- You may ask for a specific manner of communication with me. For example, you may prefer to be called at home but not at work. We will consider such requests.
- You may inspect your PHI on file and obtain a copy of your PHI, however, certain documents to include psychotherapy notes may be restricted by law. You may be charged a fee for the costs of providing a copy of your PHI.
- You may request that your PHI be corrected or amended if you feel there are any errors. We will consider such requests.
- You may revoke an Authorization for Release of Information (which allows disclosures beyond treatment, payment, or health care operations) unless such authorization was a requirement of obtaining insurance coverage. Disclosures made before you revoke an authorization, of course, cannot be undone but revoking an authorization would stop future disclosures.
- You may have a paper copy of this Notice of Privacy Practices at any time.
- You may request a listing of disclosures that we have made regarding your PHI.
- You may file a complaint against us if you feel that your privacy rights have been violated. We would like to hear directly from you if you have a complaint so that we can improve the quality of our privacy protections, however, you are not required to notify us directly. We will not, of course, penalize you if you choose to file a complaint. The agency providing oversight of your privacy rights is the Department of Health and Human Services (<http://www.hhs.gov>).

Right to Revise:

We may need to make revisions or amendments to this document over time. If any changes are made, the latest edition of the Notice of Privacy Practices will be in effect for all past, current, and future health information. We will maintain the latest edition of the notice posted in the waiting room and will give you a copy at your next visit.

I have reviewed and accepted the Privacy Practices for Tommy J. Morgan, M.D.		
_____ Signature of Patient or Guardian	_____ Printed Name of Patient or Guardian	_____ Date Signed
_____ Signature of Witness	_____ Printed Name of Witness	_____ Date Signed