

Hunterdon Radiological Associates, PA

Notice of Privacy Practices

Effective September 23, 2013

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.

Our Hunterdon Radiological Associates, P.A. affiliates, Hunterdon Radiology and Hunterdon Imaging, are committed to maintaining the privacy of your protected health information (PHI). We are required by law to give you this Notice that describes our legal duties and privacy practices concerning your health information. If you have any questions about this Notice, please contact our Privacy Office at the address listed at the end of this Notice.

I. OUR PLEDGE REGARDING MEDICAL INFORMATION:

We understand that medical information about you and your health is personal and we are committed to protecting medical information about you. We create a record of the care and services you receive at Hunterdon Radiological Associates, P. A. We need this record to provide you with quality care and to comply with certain legal requirements.

This notice applies to all of the records of your care generated by our Practice and tells you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- Make sure that medical information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices concerning medical Information about you; and
- Follow the terms of the notice that is currently in effect.

II. USES AND DISCLOSURES OF YOUR PHI THAT DO NOT REQUIRE YOUR AUTHORIZATION:

In general, when we release your health information, we must release only the information needed to achieve the purpose of the use or disclosure. We are permitted by law to use and disclose your PHI without your written or other form of authorization under certain circumstances as described below. This means that we do not have to ask you before we use or disclose your PHI for purposes such as to provide you with treatment, seek payment for our services, or for health care operations.

1. **Treatment.** We are permitted to use and disclose your PHI to provide you with medical treatment or services. For example, we are permitted to disclose medical information about you to doctors, technicians, healthcare students, or other Facility personnel who are involved in your care at our Facility.
2. **Payment.** We are permitted to use and disclose medical information about you in order to bill and receive payment for the services you receive at our Facility. For example, in order to receive payment from your insurance company, we might need to provide specific health information to your health insurance plan about your diagnosis or health services you received at our Facility. We are permitted to tell your health insurance plan about a treatment or service you are going to receive and your diagnosis in order to obtain pre-authorization or to determine whether your plan covers the treatment or service.
3. **Health Care Operations.** We are permitted to use and disclose your health information for Facility operations. These uses and disclosures are necessary to run the Facility and help to assure that we provide quality services to all of our patients. For example, we are permitted to use medical information to evaluate the performance of the staff in caring for you and to assist us in making improvements in the care and services we offer. We are permitted to disclose your medical information to organizations that accredit diagnostic imaging facilities as a part of our accreditation surveys.

4. **Other Healthcare Providers.** We may disclose your PHI to other health care professionals where it may be required by them to treat you, to obtain payment for the services they provided you with, or their own health care operations.

5. **Disclosures to Relatives, Close Friends, Caregivers.** We may disclose your PHI to family members and relatives, close friends, caregivers or other individuals that you may identify so long as we: a) Obtain your agreement; b) Provide you with the opportunity to object to the disclosure and you do not object; or c) We reasonably infer that you would not object to the disclosure. The opportunity to consent may be obtained retroactively in emergency situations. You may identify those individuals who you authorize to receive your health information or restrict these disclosures by informing the registration staff when you register at our Facility.

6. **Appointment Reminders/New Treatments.** Unless you request that we do not, we are permitted to use your health information to provide you with appointment reminders or other information about treatment alternatives or health-related benefits or services that we offer that might be of interest to you. For example, we are permitted to contact our female patients to announce new services we are offering in the area of Breast Cancer Awareness.

7. **As required or permitted by law.** Under certain circumstances, we are required to report specific health information to legal authorities, such as law enforcement officials, court officials, or government agencies. For example, we are permitted to disclose your health information in relation to cases of abuse, neglect, domestic violence or certain physical injuries, or to respond to a subpoena or court order.

8. **For public health activities.** We are, at times, required to report your health information to authorities to help prevent or control disease, injury, or disability. This might include disclosing information in your medical record to report certain diseases, injuries, birth or death information to the Health Department, information of concern to the Food and Drug Administration, or information related to child or vulnerable adult abuse or neglect.

9. **For health oversight activities.** We are permitted to disclose your health information to a health oversight agency for monitoring and oversight activities authorized by law. This might include release of information to the State agency that licenses our Facility for the purpose of monitoring or inspecting our Facility related to that license. This will also include the release of information to organizations responsible for government benefit programs such as Medicare or Medicaid.

10. **For research.** Although generally we will ask for your written authorization for any use or disclosure of your PHI for research purposes, we may use or disclose your PHI under certain circumstances without your written authorization where an authorized Institutional Review Board has waived the authorization requirement.

11. **To avoid a serious threat to health or safety.** As required by law and standards of ethical conduct, we are permitted to release your health information to the proper authorities if we believe, in good faith, that such release is necessary to prevent or minimize a serious and approaching threat to your, the public's, or another individual's health or safety.

12. **For military, national security, or incarceration/law enforcement custody.** If you are involved with the military, national security or intelligence activities, or you are in the custody of law enforcement officials or an inmate in a correctional institution, we are permitted to release your health information to the proper authorities so they may carry out their duties under the law. We are permitted to release medical information about you to authorized federal officials so that they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

13. **For workers' compensation.** We are permitted to disclose your health information to the appropriate persons in order to comply with the laws related to workers' compensation or other similar programs.

III. USES AND DISCLOSURES OF YOUR PHI THAT REQUIRE YOUR WRITTEN AUTHORIZATION

In general, we will need your **specific written authorization** on our HIPAA Authorization Form to use or disclose your PHI for any purpose other than those listed above in Section II. For example, we would need your authorization in order to use any of your PHI to mail or email you marketing materials and for disclosures that constitute a sale of PHI. However, we may provide you with marketing materials face-to-face without obtaining authorization, in addition to communicating with you about services or products that relate to your treatment, case management, or care coordination, alternative treatments, therapies, providers or care settings.

If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided

IV. YOUR INDIVIDUAL RIGHTS WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION:

You have the following rights regarding medical information we maintain about you:

1. **Right to Inspect/Copy PHI.** With a few exceptions, you have the right to inspect and obtain a copy of your medical record that we maintain. For PHI that we maintain in electronic form, you may request a copy of such PHI in a reasonable electronic format, if readily producible

If you wish to inspect or request copies of your medical record from us, please submit your request in writing to Sandra McKown, Privacy/Compliance Officer to the address at the end of this Notice. We may charge you a reasonable fee for paper copies of your PHI or the amount of our reasonable labor costs for a copy of your PHI in an electronic format.

2. **Right to Amend.** If you believe the health information within your medical record is incorrect, you may ask us to amend the information by contacting the Privacy/Compliance Officer in writing. Please include the requested amendment along with a reason as to why your health information should be amended. We are not required, to honor your request if: a) we did not create the information you are requesting be amended, b) the information is not part of the medical information kept by our Practice or otherwise unavailable for inspection; or c) if it is our professional opinion that the information in your record is accurate and complete.

3. **Right to Request Restrictions.** You have the right to request restrictions be placed on our use and disclosure of your PHI, such as a) For treatment, payment and health care operations; b) To individuals involved in your care or payment related to your care, or c) To notify or assist individuals to locate you or obtain information about your condition.

Although we will carefully consider all requests for additional restrictions on how we will use or disclose your PHI, we are not required to grant your request unless your request relates solely to disclosure of your PHI to a health plan or other payor for the sole purpose of payment or health care operations for a health care item or service that you or your representative have paid us for in full and out-of-pocket. Requests for restrictions must be in writing. Please contact the Privacy/Security Officers if you wish to request a restriction.

4. **Right to Request Confidential Communication.** You have the right to request that we communicate your health information to you by different means or places. For example, you may ask to receive information about your health status in a special, private room or through correspondence sent to a private address. To request confidential communications you must make your request in writing to our Privacy/Compliance Officer. We will not ask you the reason for your request. We will accommodate all

reasonable requests. Your request must tell us how or where you wish to be contacted. If you do not tell us how or where you wish to be contacted, we do not have to follow your request.

5. **Right to an Accounting of Disclosures.** You have the right to ask for a list of the disclosures of your health information we have made within the period of six (6) years from the date of your request for accounting. This listing will include the date of each disclosure, who received the disclosed health information, a brief description of the health information disclosed, and the reason for the disclosure. This listing will not include the following disclosures:

- Disclosures made for the purpose of treatment, payment or healthcare operations or disclosures made to family or responsible caregivers as described above
- Disclosures made directly to you
- Disclosures made based on a valid authorization from you or from your legally authorized representative
- Oral or incidental disclosures
- Disclosures made for purposes of national security or to correctional institutions or law enforcement officers as described above

Please contact the Privacy/Compliance Officer at the address at the end of this Notice. We will generally respond to your request within thirty (30) days from receipt of the request. There is no charge to you for the list, unless you request such a list more than once per year.

6. **Right to a Paper Copy of this Notice.** Upon your request, you may at any time receive a paper copy of this Notice. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

Copies of our Notice are given to each patient by the Registration staff at the time they check in for their appointment.

7. **Right to Breach Notification:** You have the right to be notified of any breach of your unsecured healthcare information.

V. CHANGES TO THIS NOTICE:

This Notice is effective as of September 23, 2013. We will abide by the terms of this Notice as is currently in effect; however, we may change this notice at any time. Changes to this Notice will apply to all PHI that we maintain. However, if we do change this Notice, we will only make changes to the extent permitted by law. We will also make the revised Notice available to you by posting it in a place where all individuals seeking services from us will be able to read the Notice as well as on our website at <https://hra.portalforpatients.com>.

In addition, each time you are seen for treatment or health care services at our office, we will offer you a copy of the current notice in effect.

VI. COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our practice or file a written complaint with the Office of Civil Rights of the U.S. Department of Health and Human Services. To file a complaint with our practice, please contact our Privacy/Compliance Officer, Sandra McKown, at Hunterdon Radiological Associates, P. A., P. O. Box 5388, Clinton NJ 08809, telephone: (908) 806-2700 ext. 215, email: contactus@hunterdonradiology.com.

We will NOT retaliate against you if you file a complaint with us or the Office of Civil Rights.