

Fairfax Family Practice Centers - Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW PROTECTED MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice is first in effect on April 3rd, 2003

This notice covers all information in our written or electronic records which concerns you, your health care, and payments for your health care. It also covers information we may have shared with other organizations to help us provide your care, get paid for providing care, or manage some of our administrative operations.

FAIRFAX FAMILY PRACTICE CENTERS (FFPC) physicians and staff may use and disclose medical information (protected health information or PHI) about an individual for:

- a. **Medical Treatment** – i.e.; providing medical care services, sending/coordinating medical care information with other health care providers caring for you, ordering and obtaining off site tests/results, writing prescriptions, etc.
- b. **Payment** – i.e.; submitting insurance claims on your behalf for treatment rendered.
- c. **Health care operations** – i.e.; internal business planning activities and quality of care evaluation.

FAIRFAX FAMILY PRACTICE CENTERS is permitted or required, under specific circumstances, to use or disclose protected health information without the individual's written authorization, including, but not limited to:

- a. **Disclosures required by law**
- b. **Disclosures to avert serious threats to health or safety**
- c. **Disclosures with reference to workers' compensation or Food and Drug Administration**

Other uses and disclosures will be made only with the individual's written authorization, and the individual may revoke such authorization. {Please see below for identifying persons to whom you would allow disclosures of otherwise protected information.}

Fairfax Family Practice Centers (FFPC) may contact the individual to provide appointment reminders or information about treatment or other health-related benefits and services that may be of interest to the individual or patient. FFPC will routinely contact patients via telephone or secured email at home and/or work and, unless otherwise requested, may leave messages on the appropriate voice mail or answering service regarding appointments, test results, etc.

Our patients have the following rights regarding their protected health information:

- a. The right to request restrictions on certain uses and disclosures of protected health information. FFPC is not required to agree to a requested restriction, however.
- b. The right to receive confidential communications of protected health information, as applicable.
- c. The right to inspect and copy protected health information, as provided in the Privacy Regulation.
- d. The right to amend protected health information, as provided in the Privacy Regulation.
- e. The right to receive an accounting of disclosures of protected health information.
- f. The right to obtain a paper copy of the Notice from the covered entity upon request. This right extends to an individual who has agreed to receive the Notice electronically.

FFPC is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information. FFPC is required to abide by the terms of the Notice currently in effect.

FFPC reserves the right to change the terms of this Notice. The new Notice provisions will be effective for all protected health information that it maintains. FFPC will provide individuals or patients with a revised Notice by posting new regulations in each office.

Individuals may complain to FFPC and to the Secretary of the Department of Health and Human Services, without fear of retaliation by the organization, if they believe their privacy rights have been violated. FFPC's contact person for matters relating to complaints is:

Lauri Rustand – Fairfax Family Practice Centers (FFPC) Privacy Official
12011 Lee Jackson Memorial Hwy., Suite #504
Fairfax, VA 22033
Ph: 703.391.2031

Please provide the name(s) of person(s) if any, to whom you would permit Fairfax Family Practice Centers (FFPC) to disclose personal health information as necessary for your continued health care. Please also note if specific health care information cannot be disclosed (i.e.; test results, appointment information, etc.) Otherwise, we will disclose only what is necessary for your continued health care in accordance to this Privacy Policy.

List Below those individuals (family, friends, interpreter services, etc.) you will allow disclosure of your personal health information from FFPC as necessary during the course of your health care services:

| Name and Relation (circle one) | Allowed Disclosure(s) Please circle ALL or specify |
|---------------------------------------|---|
| Spouse: _____ | All or Specify: _____ |
| Family/Friend-Name: _____ | All or Specify: _____ |
| Family/Friend-Name: _____ | All or Specify: _____ |
| Family/Friend-Name: _____ | All or Specify: _____ |
| Family/Friend-Name: _____ | All or Specify: _____ |

___ Initial if you will allow interpreter services if necessary for communication with health care providers

___ (Initial) I acknowledge and understand that Fairfax Family Practice Centers' policy is to send copies of test results and/or other medical information to physicians who either ordered the procedure/consult or are in need of this health information to ensure coordinated and effective diagnosis and treatment. i.e.; your designated primary care provider or physicians/dentist seen for consult/treatment. FFPC's policy is to only disclose specific information necessary for coordination of your health care or medical treatment.

List below physician providers who you **DO NOT** want specified private health information sent which could be sent in the usual course of facilitating or coordinating medical treatment.

DO NOT SEND PHI: Provider Name: _____ All or Specify: _____

DO NOT SEND PHI: Provider Name: _____ All or Specify: _____

___(Initial) I acknowledge and understand Fairfax Family Practice Centers' policy to contact me by various means when necessary for my health care services that may include my home/work/cell phone, fax, and/or email. I also understand that private health information may be included in that communication to me.

I **do NOT** want FFPC to use the following methods of communication which may include my private health information: **Please list:**

I hereby acknowledge that I have read pages 1 and 2 of Fairfax Family Practice Centers Notice of Privacy Practices version 7.1.08 and received a copy (if requested).

Signature: _____ Date: _____
Printed Name: _____