

Gahanna Family Practice, Inc.

4550 N. Hamilton Rd., Gahanna, Ohio 43230

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Notice of Privacy Policy

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your individually identifiable health information. This is also a consent for treatment, consent for release of information by payment and healthcare operations, and consent for contacting you by mail or by the telephone. Please review this notice carefully!

I This is a formal notification, as required by CMS (Centers for Medicare and Medicaid Services) concerning the privacy policy of this practice. It is important that all patients and staff understand the importance of guarding patient information. This practice has a legal obligation to maintain all medical records and information in the strictest of confidence as required by law. What this means to the patient is that we must safeguard patient information. This means we cannot release information to others without your written consent, including conversations, reminder calls, test results, and other information that may be of a confidential nature, such as having someone on your behalf come to our office to pick up prescriptions, samples, x-rays, and other paperwork. Patient information about health care is identified as "PHI" or protected health information.

This change in policy requires that you, the patient, identify and clarify at the time of registration or re-registration with this practice, who we can talk to, how we can leave information on your behalf, who can pick up material that contains your PHI and the process for ongoing continuity of your medical care. **You can change this information at any time by written notification.** Changes can only impact the care or information from that point in time forward.

II I, with my signature, authorize **Gahanna Family Practice, Inc.**, and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health (or the identified person) and may include (but not limited to) blood draws, allergy shots, preventive, diagnostic therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment or review of physical or mental status/function of the body and the sale or dispensing of drugs, devices, equipment or other items required and in accordance with are prescription. This consent includes and discussion with other health care professional for care and treatment, such as but not limited to outside X-Ray interpretations, photographed evidence of illness if necessary. I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities.

III Your protected health information (PHI) is an intricate part of your medical care, and can be used or disclosed with your written consent as follows:

- For your treatment in this practice and other locations under the physicians immediate care. This may include any referral for services and treatment related to your condition or medical care needs such as blood draws, x-rays, mailings, faxing, or e-mailing of your PHI. This may also include conversations with other physicians or their staff, and physicians in training.
- For obtaining payment for treatment with your identified insurance or health coverage program. This would include any documentation related to this process, which may include history forms, progress notes or operative notes. This would include eligibility verification, prior authorization, and claim submission.
- For operations of this practice, such as enrolling with insurance programs, hospital privileges, accounting and compliance with federal and state laws and regulations.
- Appointment reminders, confirmations, re-scheduling needs and health related services.
- Disclosure to your family and friends concerning any health care information with your consent on the registration form which can be modified at any time **in writing.**
- **Consent is not required for emergency care and treatment. An emergency is identified as a medical condition that in the judgment of the physician or medical entity requiring immediate and full information for care on your behalf.**

These items can be disclosed without your consent:

- Disclosure required by the government or law enforcement agencies. Specific areas that require release include gun shot wounds, domestic violence, and victims of abuse or neglect.
- Information used for public health purposes, medical examiners or related to a person's death or for the health department for disease tracking such as immunization records and communicable diseases.
- Information used for health care oversight, such as site review by an insurance program
- Information related to organ donation
- Information related to certain research procedures, the majority of this information is stripped of any personal data, and is normally generic (age, sex, diagnosis) in nature.
- Information provided to **avoid harm** if there is a threat to patient or other person.
- Specific governmental functions
- Workers compensation review

Your rights with respect to your protected health information:

- The right to request limits on the uses and disclosure at registration or any time during your care
- The right to choose how we send this information to you, including an alternate address.
- The right to see and obtain copies of this information within a reasonable time frame set by the physician, but there may be a copy and postage fee.
- The right to get a listing of who we have made disclosures to about your PHI that is not treatment, payment, or operations related.
- The right to correct and update your file through an amendment process if appropriate.

IV This practice reserves the right to modify or change this Privacy statement and Consent process at any time. Revision to the Notice will be available upon request by contacting the office. The changes will be effective retroactively to the initial date of the Privacy Notice and Consent. An updated Privacy Notice and Consent will be posted in the office within 90 days of the revision.

V If you have any concern or complaint about how your protected health information is being used, from this time forward you should first contact our office to see if we can resolve your concerns.

- Contact our office and complete a complaint form for review and discussion:

Dr. Susan Lake
4550 North Hamilton Road, Gahanna, Ohio 43230
(614) 428-8200

- If you are not satisfied with this response, you may report the practice to:

Office of Civil Rights
Regional Manager
Department of Health and Human Services
233 N. Michigan Ave. Suite 240
Chicago, Illinois 60601

Or the local Medicare Part B Intermediary

GBA Palmetto
Part B Operations – HIPAA Compliance Concern
P.O Box 182957
Columbus, Ohio 43218