Austin Kidney Associates, PA
Notice of Privacy Practices

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 notice describes our privacy practices. You can request a paper copy of this notice at any time. For more information about this notice or our privacy practices and policies, please contact our front office. We are required by law to protect the privacy of your health information, to provide you with this notice of our legal duties and privacy practices with respect to protected health information, to notify you following a breach of unsecured protected health information, and to abide by the terms of the notice of privacy practices currently in effect.

We may disclose your health information without your authorization for the reasons described below. We may make the described disclosures in electronic format.

Treatment: We are permitted to use and disclose your health information to those involved in your treatment. For example, when we provide treatment, we may request that your primary care physician share your medical information with us.

Payment: We are permitted to use and disclose your health information to bill and collect payment for the services that we provide to you. For example, we may complete a claim form to obtain payment from your insurer or HMO. The form will contain medical information, such as a description of the medical service provided to you, that your insurer or HMO needs to approve payment to us. Also, we may provide your primary care physician information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any.

Health Care Operations: We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered. For example, we may engage the services of a professional to aid this practice in its compliance programs. This person will review billing and medical files to ensure we maintain our compliance with regulations and the law.

Public Health, Abuse or Neglect, and Health Oversight: We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (like births and death), or injury by a public health authority. We may disclose medical information, if authorized by law, to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. We may disclose your medical information to report reactions to medications, problems with products, or to notify people of recalls of products they may be using.

We may also disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law requires physicians to report child abuse or neglect. Regulations also permit the disclosure of information to report abuse or neglect of elders or the disabled.

We may disclose your medical information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and inspections which are all government activities undertaken to monitor the health care delivery system and compliance with other laws, such as civil rights laws.

Legal Proceedings and Law Enforcement: We may disclose your health information in the course of judicial or administrative proceedings in response to an order of a court (or an administrative decision-maker) or other appropriate legal process. We may disclose your health information to law enforcement officials for law enforcement purposes. We may also disclose your health information if we believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.

Workers' Compensation: We may disclose your health information as required by the Texas workers' compensation law.

Inmates: If you are an inmate or under the custody of law enforcement, we may disclose your health information to the correctional institution or law enforcement official. This disclosure is permitted to allow the institution to provide you with medical care, to protect your health or the health and safety of others, or for the safety and security of the institution.

Military, National Security and Intelligence Activities, Protection of the President: We may disclose your health information for specialized governmental functions such as separation or discharge from military service, requests as necessary by appropriate military command officers (if you are in the military), authorized national security and intelligence activities, as well as authorized activities for the provision of protective services for the President of the United States, other authorized government officials, or foreign heads of state.

Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors: When a research project and its privacy protections have been approved by an Institutional Review Board or privacy board, we may disclose health information to researchers for research purposes. We may disclose health information to organ procurement organizations for the purpose of facilitating organ, eye, or tissue donation if you are a donor. Also, we may disclose your health information to a coroner or medical examiner to identify a deceased or a cause of death. Further, we may disclose your health information to a funeral director where such a disclosure is necessary for the director to carry out his duties.

Required by Law: We may disclose your health information where the disclosure is required by law.

Appointment Reminders, Treatment Alternatives, and Other Health-related Benefits: We may contact you by telephone, mail, or both to provide appointment reminders, information about treatment alternatives, or other health-related benefits.

Fundraising: We may use or disclose to certain third parties demographic information about you and limited information regarding your care for the purpose of raising funds. You have a right to opt out of receiving such communications. Your decision to opt out of such communications will not affect the care that we provide to you.

Individuals Involved in Your Care or Payment for Your Care: We may disclose your PHI to a family member, other relative or close personal friend or any other person identified by you who is involved in your medical care or payment for your medical care, unless you object to such disclosure. If we make such disclosure, we will only provide the PHI that is directly related to such person's involvement with your health care or payment for your health care. We may also make such a disclosure after your death, unless such disclosure is contrary to your expressed preference. We may use or disclose your PHI in order to notify or assist in notifying a family member, personal representative, close personal friend, or other person responsible for your care of your location, general condition or death. In addition, we may disclose your PHI to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location. Please notify the Privacy Officer at the number provided below if you object to any of the disclosures described in this paragraph.

In all other situations not described in this notice we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization that allows us to disclose your protected health information, you can later revoke that authorization, in writing, to stop future uses and disclosures. However, such revocation will not apply to any disclosures or uses already made or taken in reliance on that authorization. The types of uses and disclosures that require an authorization include:

Psychotherapy Notes: We must obtain an authorization from you to use or disclose psychotherapy notes unless the disclosure is made (a) for certain enumerated treatment, payment or health care operations; (b) as required by law; (c) for health oversight activities (with respect to the originator of the psychotherapy notes); (d) to a coroner or medical examiner for purposes of determining a cause of death; or (e) to prevent a serious threat to health or safety.

Marketing: We must obtain an authorization for any use or disclosure of your protected health information to communicate with you about a product or service that encourages you to use or purchase the product or service unless the communication is either a face-to-face communication or a promotional gift of nominal value. This does not include refill reminders, information regarding your course of treatment, case management or care coordination, to describe a health-related product or service that we provide, or contacting you in connection with treatment alternatives. If the marketing involves financial remuneration, we must notify you if such remuneration is involved.

Sale of Protected Health Information: We must obtain an authorization for any disclosure of your protected health information which is a sale of protected health information and such authorization must state that the disclosure will result in our receipt of financial remuneration.

<u>You have the following rights with respect to your protected health information.</u>

Requested Restrictions: You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or healthcare operations. We do NOT have to agree to this restriction, except if you pay for a service entirely out-of-pocket. If you pay for a service entirely out-of-pocket, you may request that information regarding the service be withheld and not provided to a third party payor. We are obligated by law to abide by such restriction. If we do agree to your requested restriction, we will comply with your request except

under emergency circumstances. To request a restriction, submit the following in writing: (a) the information to be restricted, (b) what kind of restriction you are requesting (i.e. on the use of information, disclosure of information or both), and (c) to whom the limits apply.

You may also request that we limit disclosure to family members, other relatives, or close personal friends that may or may not be involved in your care.

Receiving Confidential Communications by Alternative Means: You may request that we send communications of protected health information by alternative means or to an alternative location. We are required to accommodate only **reasonable** requests. This request must be made in writing. Please specify in your correspondence exactly how and where you want us to communicate with you.

Inspection and Copies of Protected Health Information: You may inspect and/or copy health information that is maintained in your medical or health record. Texas law requires that requests for copies be made in writing and we ask that requests for inspection of your health information also be made in writing.

Texas law requires that we provide copies within 15 days of your request and payment of the reasonable fee. If you request a copy of your electronic health record, we will provide such record to you in electronic form unless you agree to accept the record in another form. We may charge you a fee based upon the cost of providing you with copies of your health information, as allowed by federal and state law.

Amendment of Health Information: You may request an amendment of your health information maintained in a designated record set. Any such request must be made in writing. We may refuse to allow an amendment under certain circumstances. However, even if we refuse to allow an amendment you are permitted to include a patient statement about the information at issue in your medical record.

Accounting of Certain Disclosures: The HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosures made of your health information, except for disclosures made for the purpose of treatment, payment, health care operations and certain other purposes if such disclosures were made through a paper record or other health record that is not electronic, as set forth in federal regulations. After January 1, 2011, if you request an accounting of disclosures of your protected health information, the accounting will include disclosures made for the purpose of treatment, payment and health care operations to the extent that disclosures are made through an electronic health record, if required by then-applicable regulations. Any such request must be made in writing. Your request must state the period of time for which you are seeking the accounting of disclosures, which may not begin more than six years before the date of your request for disclosures of PHI not from electronic health record or three years for disclosures of PHI from an electronic health record. Your first accounting of disclosures (within a 12 month period) will be free. For additional requests within that period we are permitted to charge for the cost of providing the list. If there is a charge we will notify you and you may choose to withdraw or modify your request **before** any costs are incurred.

Complaints

If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also file a written complaint with the Secretary of the Department of Health and Human Services. We will not retaliate against you for filing a complaint.

Contact Information

If you have any questions or want to make a request pursuant to the rights described above, please contact:

Austin Kidney Associates, PA
408 W 45th Street
Austin, Texas 78751
Attention: Privacy Officer
512-320-1500

This notice is effective on the following date: January 1, 2014

Changes to this Notice

We may change our policies and this notice at any time for all the protected health information we maintain. If we change our notice, we will post the new notice in the office where it can be seen.

AUSTIN KIDNEY ASSOCIATES, PA
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, I acknowledge receipt of the Notice of Privacy Practices of Austin Kidney Associates. The Notice of Privacy Practices provides information about how Austin Kidney Associates may use and disclose my protected health information.

I acknowledge receipt of the Notice of Privacy Practices of Austin Kidney Associates.

_____ Date: _____
(Patient/Parent/Conservator/Guardian)

FOR AUSTIN KIDNEY ASSOCIATES USE ONLY

Inability to Obtain Acknowledgement

To be completed only if no signature is obtained. If it is not possible to obtain the patient's acknowledgement, describe the good faith efforts made to obtain the patient's acknowledgement, and the reasons why the acknowledgement was not obtained:

_____
_____
_____
_____
_____

Signature of Austin Kidney Associates
representative: _____ Date: _____