
**NOTICE OF PRIVACY
POLICIES AND PRACTICES
FOR
WOMEN'S PRIMARY CARE**

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

INTRODUCTION

At Women's Primary Care, we are committed to treating and using protected health information about you responsibly. This notice describes the personal information we collect, and how and when we may use or disclose that information. It also describes your rights and how they relate to your protected health information. This notice is effective August 1, 2006 and applies to all protected health information as defined by federal regulations.

Understanding what is in your record and how your health information is used helps you to ensure its accuracy, determine what entities have access to your health information, and make an informed decision when authorizing the disclosure of this information to other individuals.

YOUR RIGHTS

Right to Inspect and Copy You must submit a written request in order to inspect and/or copy your health information. If you request a copy of the information, we may charge you related fees. We may deny your request to inspect and/or copy in certain limited circumstances. Under these circumstances, we will respond to you in writing stating why we will not grant your request and describe any rights you may have to request a review of the denial.

Right to Amend If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- We did not create, unless the person or entity that created the information is no longer available to make the amendment.
- Is not part of the health information that we keep.
- You would not be permitted to inspect and copy.
- Is accurate and complete.

Right to an Accounting of Disclosures This is a list of the disclosures we have made of medical information about you for purposes other than treatment, payment and health care operations. To obtain this list, you must submit your request in writing. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions You have the right to request a restriction or limitation on the health information we use or disclose about you. All requests must be in writing. If we agree, we will comply with your request unless the information is needed to provide you emergency treatment.

Right to Request Confidential Communications You have the right to request, in writing, that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice You may ask us to give you a copy of this notice at any time.

HOW WE MAY USE AND/OR DISCLOSE YOUR HEALTH INFORMATION

We will use your health information for treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or may be consulted by staff members.

We will use your information for payment. Your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated in order to pay for services rendered to you. We may also tell your health plan about a treatment you are going to receive in order to obtain prior approval, or to determine whether your plan will cover treatment.

We will use your information for regular health care operations. Your health information may be used as necessary to support the day-to-day activities and management of Women's Primary Care. For example, information on the services you received may be used to support budgeting and financial reporting and activities to evaluate and promote quality.

Communication with family. We may share with a family member or other person identified by you, health information related to that person's involvement in your care or payment for your care. Please inform the practice in writing when you do not wish a family member or other individual to have authorization to receive your information.

Appointment reminders. The practice may use your information to remind you about upcoming appointments. Typically, appointment reminders are in the form of a brief, non-specific message left on your home answering machine. If you don't approve of this method, or if you prefer alternative methods, please inform the practice in writing.

SPECIAL SITUATIONS

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

To Avert a Serious Threat to Health or Safety

We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Required By Law

We will disclose health information about you when required to do so by federal, state or local law.

Research

We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

Organ and Tissue Donation

If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

Military, Veterans, National Security and Intelligence

If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you.

Workers' Compensation

We may release health information about you for workers' compensation or similar programs.

Public Health Risks

We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Health Oversight Activities

We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes

If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

Law Enforcement

We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

Coroners, Medical Examiners and Funeral Directors

We may release health information to a coroner or medical examiner to identify a deceased person or determine the cause of death.

Information Not Personally Identifiable

We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization*. If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization*, in writing, at any time. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission.

Changes to This Notice. We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office, and you are entitled to a copy of the notice currently in effect.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions, complaints, or would like additional information regarding this notice or the privacy practices of Women's Primary Care, please contact:

Privacy Officer
Women's Primary Care
1617 Ronald Drive
Raleigh, NC 27609
(919)871-0301

If you believe that your privacy rights have been violated, please contact the aforementioned practice Privacy Official or the Secretary of the Department of Health and Human Services. There will be no retaliation for filing a complaint with either the practice's Privacy Official or with the Department of Health and Human Services.

Women's Primary Care
Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information (PHI) by Women's Primary Care for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations (TPO).

I have the right to review Women's Primary Care's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes my rights and the duties of Women's Primary Care with respect to my PHI and is provided at the office and on their web site at <http://womensprimarycare-raleigh.com/forms/wpchipaa.pdf>

Women's Primary Care reserves the right to revise its Notice of Privacy Practices at any time. I may obtain a revised Notice of Privacy Practices by accessing the Women's Primary Care's web site, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

With my consent, Women's Primary Care may call my home or other designated location and leave a message in reference to any items that assist the practice in carrying out TPO. Some examples are appointment reminders, insurance items and calls pertaining to my care, including laboratory results.

In order to protect your privacy, we need to know:

Best phone number to reach you: _____

If work, can we leave a message for you to call us back? _____

If home, can we leave a detailed message on your answering machine/voice mail? _____

May we speak with a family member regarding your care? _____

Is there anyone we may not leave a message with or speak to? _____

If yes, please list: _____

Is there an email address that you would like us to use to contact you? _____

If so, please provide: _____

With my consent, Women's Primary Care may mail to my home any items that assist the practice in carrying out TPO, such as statements or postcards relaying appointment reminders or test results.

I have the right to request a restriction as to how my PHI is used or disclosed to carry out TPO. Women's Primary Care is not required to agree to the restrictions, however, if it does, it is bound by that agreement.

I have the right to revoke this consent, in writing, at any time, except to the extent Women's Primary Care has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Women's Primary Care may decline to provide treatment to me.

By signing this form, I am consenting to Women's Primary Care's use and disclosure of my PHI to carry out TPO.

Printed Name of Patient

Signature of Patient, Parent or Legal Guardian

Date

Printed Name of Parent or Legal Guardian