Family Medicine of Albemarle

Notice of Privacy Practices

Welcome to Family Medicine of Albemarle (FMOA). This *Notice of Privacy Practices* describes how FMOA may use your PHI (Personal Health Information) within our medical practice and disclose your PHI in order to carry out medical treatment, payment or health care operations. PHI consists of your name, date of birth, address, past and present health information. FMOA may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI. FMOA complies with the relative federal and Virginia state laws for privacy and confidentiality. Your rights and responsibilities are also described in this document. ***We ask that you read this form carefully and ask us any questions you may have about the form or the services FMOA provides.*** You will be asked to sign at the end of this section noting that you have read and understand these practices, as well as, provide consent.

Use and Disclosures of Personal Health Information

Your PHI, by law, may be used and disclosed by physicians, nurse practitioners, physician assistants, registered nurses, and administrative staff who are employed or contracted by FMOA without your prior consent upon signing this section for the following purposes:

- To share your PHI with other community healthcare providers who are directly involved in your care, such as a referral to a specialist for treatment purposes
- To be reviewed for quality assurance and internal quality initiatives to improve healthcare practices
- To obtain payment for services
- To bill or collect payment for services
- To share information with your health plan to determine if the service is eligible for payment
- To insurance companies, in order to obtain pre-authorization approval for a test or a type of x-ray, for example.
- Debt referral to collection agencies

FMOA may use and disclosure your PHI, upon completion of your signature on this consent, in the following situations:

1. **Public Health needs/risk:** Within the Albemarle County there are certain diseases that must be reported to the public health department to prevent and control disease. We may also notify individuals who may have been exposed to a contagious disease in the effort to decrease the spread.
2. **Legal and law enforcement purposes:** FMOA is required by law to report abuse in minor aged students (<18 years). FMOA must also comply with legal proceedings which relate to subpoenas or other investigations.
3. **Minors:** FMOA may disclose the PHI of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.
4. **Coroner's Office**: FMOA may disclose PHI to any medical examiner to assist with the identification of cause of death duties.
5. **Worker's compensation:** Any health information needed to process this form and directly related to the compensation laws may be released.
6. **Harm of self or other:** By State mental health laws, health information may be disclosed to non-healthcare professionals if there is deemed a significant need in which you may harm yourself or others, including the greater community.
7. **Organ and Tissue Donation:** If you are an organ or tissue donor, we may use or disclose your PHI to organization that handle organ procurement or transplantation as necessary to facilitate organ or tissue donation or transplantation.
8. **Military Personnel and Veterans:** If you are a member of the armed forces, we may disclose PHI as required by military command authorities, domestic and foreign.
9. **Business Associates:** Some services (i.e. laboratory) are provided through the use of contracted entities. These business associates are provided only the necessary information needed to complete the service. FMOA

requires all business associates to show proof of how they safeguard your PHI and also notify FMOA in case of a breach of privacy.

10. **Appointment reminders:** FMOA will contact you if possible 24 to 36 hours prior to your appointment via phone or email. We will only leave a message on your phone if a voice mail box is set up specifically with your name.
11. **Follow up:** Part of providing excellent care is following up with patients in how they are currently feeling or future care that they may need. These reminders may be provided via email or phone.
12. **Data Breach:** FMOA may use or disclose your PHI to provide legally required notices of unauthorized access to or disclosure of your health information.
13. **Lawsuits and Disputes:** If you are involved in a lawsuit or dispute, FMOA may be required to law to disclose you PHI in response to a subpoena. FMOA may also disclose your PHI to defend ourselves in the event of a lawsuit against FMOA or its practitioners.

Your privacy rights:

- You have the right to obtain a copy of all of your health information records which have been generated by FMOA for your care. You must provide a written request to FMOA, explaining what records you need to review. There are some exceptions to records which may be copied and the request may be denied. FMOA has the right to charge for any records requested.
- You have the right to adjust your release of information or revoke the release to certain individuals. This must be in writing and only items not yet disclosed will be able to be complied with.
- You have the right to restrict disclosure to certain individuals for certain types of treatment. However, FMOA does not need to comply with these requests if they impede the healthcare of another individual or community.
- You have the right to pay for your services in cash and restrict information from being released regarding this specific care paid for in this manner, unless required by law.
- You have the right, after inspection, to amend your PHI. You will need to write the specific details that need to be amended as well as the rationale for the amendment. FMOA may deny this request as which time you will have the opportunity to disagree.
- You have the right to a list of individuals, departments, and organizations who have received your PHI. FMOA requires 30 days to comply with this request and will charge a reasonable fee for the final product.
- You have the right to receive a notice of breach of your PHI as dictated by the federal government.
- You have the right to complete a formal complaint to the FMOA Practice Administrator if you have any concerns about these privacy practices or if you feel that your information has been breached.
- You have the right to receive a paper copy of this notice at any time.
- You have the right to change permissions on this form per your request in writing.
- You will be required to sign a separate release of information form to release records to other medical or non-medical agencies.

Your responsibilities:

- You are responsible to provide privacy and courtesy to others by not recording any conversations and taking pictures without a written consent.

Privacy Officer contact information:

Practice Administrator
Administrator@fmoa-online.org
434.973.9744

Agreement:

Your consent, agreement, and understanding to these terms is indicated by your signature

_____ _____

Signature (patient/Guardian) ***Date***

_____ _____

Printed Name ***MRN/Date of Birth***

*This form will be in effect for the entire time that you are an active patient, unless significantly altered or revoked.

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Authorization for Release of Information

Please indicate to whom and how FMOA may provide financial, medical, and appointment information in the designated area below:

Name_____ Phone_____ Relationship_____	□ Financial □ Medical Information □ Prescription pick up □ Appointment Information □ Billing/Submit to claims to private and public payers
Name_____ Phone_____ Relationship_____	□ Financial □ Medical Information □ Prescription pick up □ Appointment Information □ Billing/Submit to claims to private and public payers
Name_____ Phone_____ Relationship_____	□ Financial □ Medical Information □ Prescription pick up □ Appointment Information □ Billing/Submit to claims to private and public payers

□ Do not release any of the above information without my specific request.

Please indicate if FMOA can utilize these forms of communication to disclose personal health information (PHI) such as laboratory results, pharmacy needs, or health education: **(Please note, FMOA will utilize your email or your phone number to remind you of your appointments. Only discreet information will be noted within the email or phone message).**

E-mail communication: _____	□ Financial □ Medical Information □ Prescription pick up □ Appointment Information □ Billing/Submit to claims to private and public payers
Phone communication: _____	□ Financial □ Medical Information □ Prescription pick up □ Appointment Information □ Billing/Submit to claims to private and public payers

- For email and phone communication, I understand that this is not a secure and encrypted method and I have elected to receive communication in this manner.
- My Consent will remain in effect as long as I am an active patient of Family Medicine of Albemarle. Any changes will need to be in writing.

I understand I have the right to revoke this authorization at this time and that my treatment will not be adversely affected by not signing.

_____ _____

Signature ***Date***

_____ _____

Printed Name ***MRN/Date of Birth***

*This form will be in effect for the entire time that you are an active patient, unless significantly altered or revoked.

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RELEASE OF PROTECTED INFORMATION

Your health records, maintained by Family Medicine of Albemarle (FMOA), may include information regarding drug or alcohol abuse or treatment; HIV/AIDS test results, and/or mental health services. These are considered protected by the State of Virginia and a separate release of information is required.

By signing this form, you are specifically authorizing FMOA and its physicians, health care professionals, and staff to use and disclose the following type(s) of information:

- *Information about my substance abuse (drugs(s) or alcohol) or related treatment*
- *Information about my mental health or my psychological/psychiatric care or conditions, including diagnoses and treatment recommendations*
- *Information about genetic testing/records*
- *Information about my HIV/AIDS diagnosis and treatment*

I also allow disclosure to the following individuals identified below:

Name_____ Phone_____ Relationship_____	□ Genetic □ HIV/AIDS □ Mental Health □ Substance Use/Abuse
Name_____ Phone_____ Relationship_____	□ Genetic □ HIV/AIDS □ Mental Health □ Substance Use/Abuse

_____ _____ _____

Patient/Guardian Name ***Date of Birth*** ***MRN#***

_____ _____

Witness's Printed Name (REQUIRED) ***Signature of Witness***

_____

Date

Date on which Authorization Expires (or within one year)_____

PLEASE NOTE: All authorizations for Protected Information must be signed by a witness who can attest to the patient's identity. In addition, the student must identify a date on which this authorization expires; otherwise, the authorization expires within one year of the day it is received by FMOA. An adult patient has the right to inspect and copy his or her health information disclosed under the authorization in Section II of this form. FMOA may charge a reasonable fee for copying records. If patient is ≥ 18 years old, protected information cannot be released until this portion is signed and witnessed.