

# HIPAA Omnibus Notice of Privacy Practices

## Revised 2013

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Cannon Family Health, PLLC – 6 Brooklet Street – Asheville, NC 28801 – 828-250-0898

### **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 of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

#### **USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician’s practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred, DME vendors, surgery centers/hospitals, referring physicians, family practitioner, physical therapists, home health providers, laboratories, worker comp adjusters and nurse case managers, etc to ensure that the healthcare provider has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay, surgery, MRI or other diagnostic test, injection procedures, injection series, physical therapy, etc., may require that your relevant protected health information be disclosed to the health plan to obtain approval for the procedure.

**Healthcare Operations:** We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician’s practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you.

We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

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We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures.

Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

## **USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION**

**Other Permitted and Required Uses and Disclosures** will be made **only with your consent, authorization** or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

**You may revoke the authorization**, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

## **YOUR RIGHTS**

The following are statements of your rights with respect to your protected health information.

- **You have the right to inspect and copy your protected health information (fees may apply)**
- **You have the right to request a restriction of your protected health information**
- **You have the right to request to receive confidential communications**
- **You have the right to request an amendment to your protected health information**
- **You have the right to receive an accounting of certain disclosures**
- **You have the right to receive notice of a breach**
- **You have the right to obtain a paper copy of this notice**

## **COMPLAINTS**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

**We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.**

**Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.**

Dr. Dan Cannon

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Asheville, NC 28801



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[www.CannonFamilyHealth.com](http://www.CannonFamilyHealth.com)

## Authorization

**This authorization outlines who, medical information about you may be shared.**

**Please read it carefully.**

The privacy of your medical information is important to us. Our Notice of Privacy Practices outlines how we may use or disclose your medical information on a regular basis. This authorization is for situations not included in the Notice when you may want us to share your medical information with someone else such as a spouse, other family members, or your caregiver. This Authorization allows the individual(s) listed to have access to all of your information as a patient of this practice and will be all-inclusive unless otherwise specified in the Limitations section below. This Authorization will remain in effect for a period of five years from the date signed.

### Who may receive this health information:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Limitations: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I understand that once disclosed to the individual(s) named above, Cannon Family Health cannot guarantee that the individual(s) will maintain the confidentiality of such information as described by law.

### Revocation

This Authorization will remain in effect for a period of five years from the date signed. However, you have the right to revoke this Authorization at any time as long as the revocation is made in writing and is received and acknowledged by Cannon Family Health. Such revocation will restrict disclosures of your medical information but cannot affect past disclosures or disclosures underway at the time of receipt.

Patient Signature: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date: \_\_\_\_\_

Legal Guarantor: \_\_\_\_\_ Relationship: \_\_\_\_\_ Date: \_\_\_\_\_