

# **HIPAA NOTICE OF PRIVACY PRACTICE**

**SELAH WOMEN'S HEALTH  
2216 BUENAVENTURA BLVD. SUITE B  
REDDING, CA 96001  
530-338-0002**

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. Our practice takes these policies seriously due to severe civil and criminal penalties for non compliance.

This Notice of Privacy Practices describes how we may use and disclose you 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 and future physical or mental health or condition and related health care services.

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.

We will use and disclose your protected health information to provide, coordinate, or manage you health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose and treat you.

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 may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

We may use or disclose, as needed, your protected health information in order to support the business activities of you physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, 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.

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 and National Security: Worker's Compensation: Inmates: Required Uses and Disclosures: Under the law, we must investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your written consent, authorization or opportunity to object unless required by law.

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

**Your Rights:**

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and obtain a copy of your protected health information. You, at any time, may request a copy of your medical record (all or in part). All requests for any and all medical records must be in writing and addressed to this facility. Under Federal law, however, you may not inspect or request to copy the following records, psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to the law that prohibits access to protected health information.

Your physician is not required to agree to a restriction that you request. If your physician believes it is in your best interest to permit the use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us upon written request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You have the right to have your physician amend your protected health information. If we deny your written request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice. You have the right to object or withdraw as provided in this notice.

**Complaints:** You may complain to us or 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 privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

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. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

**ACKNOWLEDGEMENT OF RECEIPT OF  
HIPAA NOTICE OF PRIVACY PRACTICE**

**SELAH WOMEN'S HEALTH  
2216 BUENAVENTURA BLVD. SUITE B  
REDDING, CA 96001  
530-338-0002**

I have been given a copy of the HIPAA notice of Privacy Practice for Selah Women's Health \_\_\_\_\_  
Initial

Under the Patient Privacy Act, also known as HIPAA, our office cannot release or discuss patient information with anyone other than the patient, legal guardian or custodial parent, unless we have written authorization from the patient.

You can choose to allow us to speak with family members or care givers regarding your healthcare by completing the following, indicating the person by full name, to whom we may speak.

I, \_\_\_\_\_ authorize Selah Women's Health to release and/or discuss my private health information with the following:

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

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

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

Entire Record \_\_\_\_\_ or Specific Information only \_\_\_\_\_

\_\_\_\_\_ I **do not** want any information released to anyone by Selah Women's Health with the exception of the Physician who referred me to this practice.

This authorization will remain in effect until I have revoked this authorization in writing. My written revocation must be submitted in writing to :

Selah Women's Health  
2216 Buenaventura Blvd Suite B  
Redding, Ca 96001

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Relationship to Patient