NOTICE OF PRIVACY PRACTICES

FAMILY PRACTICE ASSOCIATES
DOES BUSINESS AS:
FAMILY HEALTH CENTER
&
FAMILY HEALTH CONVENIENT CARE CLINIC

Your Information.
Your Rights.
Our Responsibilities.

TO OUR PATIENTS: 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.

Effective Date: June 1, 2017

If you have any questions about this notice, please contact Terri Black, Administrator for Family Health Center and Family Health Convenient Care Clinic.

This notice describes our office's practices and that of:
Any health care professional authorized to enter information into your file or record. All employees, staff and other personnel.

OUR PLEDGE REGARDING MEDICAL NFORMATION:

We understand that medical information about you and your health is personal. We are committed to protecting your medical information. We create a record of the care and service you receive in our practice. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care.

This notice will tell you about the ways in which we may use and disclose medical information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:
*maintain the privacy and security of your protected health information;
*give you this notice of your legal duties and privacy practices with respect to protected medical information about you; and let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
*follow the duties and privacy practices described in this notice and give you a copy of it.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/notice99.html.

HOW WE MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION.

The following categories describe different ways that we use and disclose protected medical information. For each category of uses of disclosures we will explain what we mean. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Treatment: We may use protected medical information about you to provide you with medical treatment or services. We may disclose protected medical information about you to doctors, nurses, technicians, medical students, pharmacists, or other personnel who are involved in taking care of you. Different departments of our practice also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays. We also may disclose protected medical information about you to people outside the practice who may be involved in your medical care, such as family members or others we use to provide services that are part of your care.

Payment: We may use and disclose protected medical information about you so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about treatment you receive so your health plan will pay us or reimburse you. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. We also may use and disclose your information to obtain payment from third parties that may be responsible for such costs, such as family members. We may use your information to bill you directly for services and items.

Appointment Reminders: We may use and disclose protected medical information to contact you as a reminder that you have an appointment for treatment or medical care.

Treatment Alternatives: We may use and disclose protected medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services: We may use and disclose protected medical information to tell you about health-related benefits or services that may be of interest to you.

Individuals Involved in Your Care or Payment of Your Care: We may disclose or release protected medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. We may also tell your family or friends your condition. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Research: Under certain circumstances, we may use and disclose protected medical information about you for research purposes. For example, a research project my involve comparing the health and recovery of all patients who receive one medication to those who receive another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research need with the patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs. We will almost always ask for your specific 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 in our practice.

As Required By Law: We will disclose protected medical information about you when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety: We may use and disclose protected medical 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. Any disclosure, however, would only be to someone able to help prevent the threat.

Organ and Tissue Donation: If you are an organ donor, we my release protected medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans: If you are a member of the armed forces, we may release protected medical information about you as required by military command authorities. We may also release protected medical information to a foreign military authority, if you are in their service.
Workers' Compensation: We may release protected medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness. Release of such information is controlled by state and/or federal law.

Public Health Risks: We may disclose protected medical information about you for public health activities. These activities generally include the following:
*to prevent or control disease, injury or disability;
*to report births and deaths;
*to report a known or suspected crime;
*to report child abuse or neglect;
*to report vulnerable adult abuse;

*to report reaction to medications or problems with products;
*to notify a person who may have been exposed to a disease or may be at risk for contracting or
spreading a disease or condition;
*to notify the appropriate government authority if we believe a patient has been the victim of
domestic violence. We will only make this disclosure if you agree or when required or authorized
by law.

Data Breach Notification Purposes: We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information**.**

Health Oversight Activities: We may disclose protected medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights law.

Lawsuits and Disputes: If you are involved in a lawsuit or dispute, we may disclose protected medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement: We may release protected medical information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, to identify or locate a suspect, fugitive, material witness, or missing person, regarding the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement, about the death we believe may be the result of criminal conduct, about criminal conduct involving our practice, and in emergency circumstances to report a crime, the

location of the crime or victims, or the identify, description or location of the person who committed the crime.

Medical Examiners and Funeral Directors: We may release protected medical information to a medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release protected medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities: We may release protected medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others: We may disclose protected information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release protected medical information about you to the correctional institution or law enforcement official. This release would be necessary for this practice to provide you with health care, to protect your health and safety or the health and safety of others, or for the safety and security of the correctional institution.

Business Associates:
Family Health Center at times contracts with third-party business associates for services. We may disclose your health information to our business associates so that they can perform the job we have asked them to do. To protect your health information, we require our business associates to appropriately safeguard your information.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

You have the following rights regarding protected medical information we maintain about you:

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. This includes medical and billing records, but does not include psychotherapy notes. To inspect and/or copy your medical information you must submit your request to Jeannie McFarland in our office. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request. (By statute in Oklahoma we may charge you no more than $1.00 for copying the first page and 50 cents for copying each additional page, plus the postage cost if the copies are sent to you. If your record contains any item(s) that are not in standard paper form and/or requires a photographic process to copy, such as an x-ray or photograph, we may charge you no more than $5.00 or the actual cost of reproduction, whichever is less.

Right to Amend: If you feel that medical 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 for as long as the information is kept by our practice. To request an amendment, your request must be made in writing and submitted to Jeannie McFarland in our office. In addition, you must provide a reason that supports your amendment request. 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:

*was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
*is not part of the medical information kept by our practice;
*is not part of the information which you would be permitted to inspect and copy;

*is in our judgment accurate and complete as it appears or as it was at the time it was originally
captured and recorded.

Right to an Accounting of Disclosures: You have the right to request an “accounting of disclosures.” This is a list of the disclosures we have made of your medical information. To request this list or accounting of disclosures, you must submit your request in writing to Jeannie McFarland in our office. Your request must state a time period, which may or may not be longer than six years and may not include dates before April 14th, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically, i.e., on disk or by e-mail).
The first list you request within each 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you for 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 protected medical information we use or disclose about you for treatment, payment or health care operations. However, we must receive your restrictions in writing before we have made such disclosures. Also, if you restrict our right to use your protected medical information for treatment, payment or health operations, we reserve the right to immediately withdraw our services from you and terminate the physician-patient relationship. You also have the right to

request a limit on the protected medical information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery to your family. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to Jeannie McFarland in our office. In your request

for restrictions, you must tell us what information you want to limit, whether you want to limit our use, disclosure or both, and to who you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications: You have the right to request 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 at home, or by mail, or by phone, or by E-mail. To request confidential communications, you must make your request in writing to Jeannie McFarland in our office. 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 Copy of This Notice: You have the right to a copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Receive Notice of a Breach: We are required to notify you by first class mail or by e-mail (if you have indicated a preference to receive information by e-mail), of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days following the discovery of the breach. "Unsecured Protected Health Information" is information that is not
secured through the use of a technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the Protected Health Information unusable, unreadable, and undecipherable to unauthorized users.

The notice is required to include the following information:
*a brief description of the breach, including the date of the breach and the date of its discovery, if known
*a description of the type of Unsecure Protected Health Information involved in the breach;
*steps you should take to protect yourself from potential harm resulting from the breach;

*a brief description of actions being taken to investigate the breach, mitigate losses, and protect against further breaches;

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for protected medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our office. The notice will contain on the first page, in the top right hand corner, the effective date. In addition, each time you are in our office for treatment or health care services, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Terri Black. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of protected medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose protected medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose protected medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provide to you.

HOURS OF OPERATION

Family Health Center

Office Hours: Monday thru Friday 8:00am to 5:00pm
Phone (580) 226-0543
Fax: (580) 226-2284

Family Convenient Care Clinic

Office Hours: Monday thru Friday 8:00am to 8:00pm
Saturday 8:00am to 6:00pm
Sunday 8:00am to 12:00noon
Phone (580) 223-6003
Fax: (580) 223-6999

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with a PATIENT PRIVACY NOTICE that provides a complete description of information uses and disclosures. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Family Practice Associates, who does business as Family Health Center and Family Health Convenient Care Clinic are not required to agree to the restrictions requested. I understand that I must revoke this consent in writing, except to the extent the organization has already taken action in reliance thereon. By Oklahoma law we are required to notify you that the information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

I authorize the release of my medical information (verbal or written) to the following person(s):

Name____________________Relationship________________
Name____________________Relationship________________
Name____________________Relationship________________
Name____________________Relationship________________

You ____may or ______may not leave appointment reminders or medical information on my message service or machine.

You ____may or ____may not fax information to me. My fax number is ___________________.

_________________________________ _____________
Signature of patient or legal representative Date