
Robert G. Salazar, M.D., Inc.

Pain Consultant

HIPAA NOTICE OF PRIVACY PRACTICES

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

UNDERSTANDING YOUR PROTECTED HEALTH INFORMATION:

Understanding what is in your health record and how your health information is used will help you to ensure its accuracy, allow you to better understand who, what, when, where and why others may access your health information, and assist you in making more informed decisions when authorizing disclosure to others. When you visit us, we keep a record of your symptoms, examination, test results, diagnoses, treatment plan, and other medical information. We also may obtain health records from other providers. In using and disclosing this protected health information (“PHI”), it is our objective to follow the Privacy Standards of the federal Health Insurance Portability and Accountability Act, 45 CFR Part 464. The law allows us to use and disclose PHI without your specific authorization for treatment, payment, operations and other specific purposes explained on the next page. This includes the sharing of information, when necessary and appropriate, with other physician’s, as necessary for your continued care. It also includes contacting you for appointment reminders and follow-up care. All other uses and disclosures require your specific authorization.

YOUR HEALTH INFORMATION RIGHTS ALLOWS YOU TO:

- Request a restriction on the uses and disclosures of PHI as described in this notice, although we are not required to agree to the restriction you request. If you have paid for services out-of-pocket, in full, and request that we not disclose your, related solely to those services, to your PHI we shall accommodate your request except where the disclosure is required by law. You should address your request in writing to the Privacy Officer. We will notify you within thirty (30) days if we cannot agree to the restriction.
- Obtain a paper copy of this Notice and upon written request, inspect and obtain a copy of your health record for a fee of \$.25 per page and the actual cost of postage per the U.S. Postal Service, except that you are not entitled to access, or to obtain a copy of, psychotherapy notes and information compiled for legal proceedings. We may deny your request to inspect and/or copy your health record in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed healthcare professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.
- Amend your health record by submitting a written request with the reasons supporting the request to the Privacy Officer. To request an amendment, complete and submit a Medical Record Amendment/Correction Form to the Privacy Officer. We will respond to your request for within sixty (60) days of receipt of your written request, unless additional time is needed to respond, at which time we may extend our response deadline for up to an additional thirty (30) days and provide you with an explanation as to the reason for the delay. 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: (1) we did not create, unless the person or entity that created the information is no longer available to make the

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amendment; (2) is not part of the health information that we keep; (3) you would not be permitted to inspect and copy; or (4) is accurate and complete.

- Obtain an accounting of disclosures of your health information, except that we are not required to account for disclosures for treatment, payment, operations, or pursuant to authorization, among other exceptions. To obtain this “accounting of disclosures,” you must submit your request in writing to the Privacy Officer. Your request must state a time period, which may not be longer than six (6) years prior to the date on which the accounting is requested. Your request should indicate in what form you want the list (for example, on paper or electronically). The first accounting in any twelve (12) month period is free of charge. Additional requests for accounting of disclosures may result in charges to you for the costs of providing such accounting. 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. We will respond to your request for an accounting of disclosures within (60) days of receipt of your written request, unless additional time is needed to respond, at which time we may extend our response deadline for up to an additional thirty (30) days and provide you with an explanation as to the reason for the delay.
- Request in writing to the Privacy Officer that we communicate with you by a specific method and at a specific location. We will typically communicate with you in person; or by letter, e-mail, fax, and/or telephone.
- Revoke an authorization to use or disclose PHI at any time except where action has already been taken.

OUR RESPONSIBILITIES AS REQUIRED BY LAW:

- Maintain the privacy of PHI and provide you with notice of our legal duties and privacy practices with respect to PHI.
- Abide by terms of the notice currently in effect. We have the right to change our notice of privacy practices and we will apply the change to your entire PHI, including information obtained prior to the change.
- Post notice of any changes to our Privacy Policy in the lobby, or on our practice website (if any), and make a copy available to you upon request.
- Notify affected individuals following a breach of unsecured PHI.
- Use or disclose your PHI only with your authorization except as described in this notice.
- Follow the more stringent law in any circumstance where other state or federal law may further restrict the disclosure of your PHI.

FOR MORE INFORMATION OR TO REPORT A PROBLEM,

CONTACT THE PRIVACY OFFICER AT:

**Robert G. Salazar, M.D., Inc.
7152 North Sharon, Suite 102
Fresno, California 93720
Telephone: 559.432.6807**

If you feel your rights have been violated, you may file a complaint in writing with the Privacy Officer. If you are not satisfied with the resolution of the complaint, you may also file a complaint with the Office of Civil Rights either writing to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/ Filing a complaint will not result in retaliation.

We may use or disclose your PHI for treatment, payment and operations, and for purposes described below:

TREATMENT

We will use and exchange information obtained by a physician, nurse practitioner, nurse or other medical professionals, staff, trainees and volunteers in our office to determine your best course of treatment. The information obtained from you or from other providers will become part of your medical records. We may also disclose your PHI to other outside treating medical professionals and staff as deemed necessary for your care. *For example*, we may disclose your PHI to an outside physician for referral. We will also provide your health care providers with copies of various reports to assist them in your treatment. If you are an athlete, and wish to have your trainer or coach notified, we may disclose PHI to athletic trainers and coaches pertaining to medical conditions that may restrict your ability to compete.

PAYMENT

We may use and disclose protected health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company, or a third party. For example, we may send a bill to your or to your insurance carrier. The information on or accompanying the bill may include information that identifies you, as well as that portion of your PHI necessary to obtain payment.

HEALTH CARE OPERATIONS

Members of the medical staff, trainees, medical students, a Risk or Quality Improvement team, or similar personnel may use your information to assess the care and outcomes of your care in an effort to improve the quality of the healthcare and service we provide or for educational purposes. *For example*, an internal review team may review your medical records to determine the appropriateness of care. There may also be times in which our accountants, auditors, health information specialists or attorneys may review your PHI to meet their responsibilities.

OTHER USES AND DISCLOSURES NOT REQUIRING AUTHORIZATION

- **Business Associates:** There are some services provided to our organization through contracts with business associates, such as laboratory and radiology services. We may disclose your health information to our business associates so that they can perform these services. We require the business associates to safeguard your information to our standards.
- **Notification:** We may disclose limited health information to friends or family members identified by you as being involved in your care or assisting you in payment. We may also notify a family member, or another person responsible for your care, about your location and general condition.
- **Legally Required Disclosures & Public Health:** We may disclose PHI as required by law, or in a variety of circumstances authorized by federal or state law. For example, we may disclose PHI to government officials to avert a serious threat to health or safety or for public health purposes, such as to prevent or control communicable disease (which may include notifying individuals that may have been exposed to the disease, although in such circumstances you will not be personally identified), federal or state health oversight agencies, child abuse or neglect, domestic violence, to an employer to evaluate work related injuries, and to public officials to report births and deaths.
- **Law Enforcement & Subpoenas:** We may disclose PHI to law enforcement such as limited information for identification and locations purposes, or information regarding suspected victims of crime, including crimes committed on our premises. We may also disclose PHI to others as required by court or administrative order, or in response to a valid summons or subpoena.
- **Information Regarding Decedents:** We may disclose health information regarding a deceased person to: 1) coroners and medical examiners to identify cause of death or other duties 2) funeral directors for their required duties and 3) to procurement organizations for purposes of organ and tissue donation.
- **Research:** We may also disclose PHI where the disclosure is solely for the purpose of designing a study, or where the disclosure concerns decedents, or an institutional review board or privacy board has determined that obtaining authorization is not feasible and protocols are in place to ensure the privacy of your health

information. In all other situations, we may only disclose PHI for research purposes with your authorization.

- **Marketing & Funding Raising:** We may contact you with information about treatment alternatives or other health related benefits and services that may be of interest to you. We may also contact you as part of a fund raising effort, unless you instruct us not to.
- **Directory Information:** We may disclose limited information regarding your name and location for directory purposes to those persons who ask for you by name or to members of the clergy. You may request that we not include your name in the directory.

DISCLOSURES REQUIRING AUTHORIZATION

The release of health information, other than those identified above, will be made with written authorization from the patient, which you have the right to revoke at any time, except to the extent we have already relied upon the authorization or in the event of an emergency.

Robert G. Salazar, M.D., Inc
Pain Consultant

William J. Johncox
D.C., P.A.-C

ACKNOWLEDGMENT OF RECEIPT

Federal law requires that we seek your acknowledgment of receipt of this Notice of Privacy Practices. Please sign below.

I acknowledge that I have received and/or been offered this Notice of Privacy Practices with an effective date of _____, and that I understand that if I have any questions regarding this Notice, I may contact the Privacy Officer.

Signature: _____ Date: _____

Printed Name : _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

Please indicate how you preferred to be contacted by providing one of the following

By phone _____

By mail: _____

For Office Use Only

Signed Acknowledgment of Receipt received on: _____

Notice of Privacy Practices sent/delivered on: _____

Patient Refused or Failed to Acknowledge Receipt on: _____