Eastern Oklahoma Orthopedic Center
Privacy Notice

Effective Date: April 14, 2003

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.

Eastern Oklahoma Orthopedic Center, Inc. (EOOC) is required by federal law to maintain the privacy of qualifying medical information and to provide you with a notice of its privacy practices. EOOC will not use or disclose your qualifying medical information except as described below. This Notice of Health Information Practices applies to all qualifying medical information generated and maintained by EOOC.

A. <u>Description of Uses and Disclosure of Medical Information</u>

The following categories describe the ways that EOOC may use and disclosed your medical information.

1. <u>Treatment:</u> EOOC may use and disclose your medical information for medical treatment purposes. Medical treatment purposes include but are not limited to the provision, coordination or management by EOOC of diagnostic, healthcare and related services, consultation between EOOC and other healthcare providers regarding medical care treatment or the referral of a patient for healthcare services from EOOC to another healthcare provider. EOOC may need to disclose medical information in order to obtain approval for a recommended treatment plan. EOOC may make disclosure of all or any portion of your medical record information to physician(s), nurses, technicians, medical students, and other health care providers who have a legitimate need for the information in connection with your medical care and treatment.

2. <u>Payment:</u> EOOC may use and disclose your medical information for payment purposes. Payment purposes include but are not limited to activities involving obtaining insurance benefits, determining eligibility or coverage under insurance policies, the coordination of insurance benefits, the adjudication or subrogation of health benefit claims, risk adjusting amounts, billing, claims management, collection activities, obtaining payment under reinsurance, related healthcare data processing, medical necessity or coverage review, utilization review and disclosure of information to consumer reporting agencies. Your medical information may be released to an insurance company, third party payer or other entity (or their authorized representatives) involved in the payment of your medical bill and may include copies of your medical record which are necessary for payment of your account.

3. <u>Routine Healthcare Operations:</u> EOOC may use and disclose your medical information during routine business operations of EOOC, including quality assurance, utilization review, medical review, internal auditing, accreditation, certification, licensing or credentialing activities of EOOC, medical research and educational purposes.

4. <u>Special Circumstances That May Require Release of Medical Information Without Written Consent:</u>

   a. Federal, State or Local law in connection with Public Health Activities or concerns.
   b. Victims of abuse, neglect or domestic violence.
   c. Health oversight activities as authorized by law.
   d. Law enforcement purposes in response to a valid subpoena or court order.
   e. Coroner, Medical Examiners, Funeral Directors.
   f. Organ Procurement Organizations for the purposes if tissue donation and transplantation.
   g. Researchers whose clinical research study has received approval which complies with applicable law.
   h. Prevention or lessen a serious and imminent threat to the health or safety of a person or the public.
   i. Specialized Government Functions such as: military command authorities if you are in the military or a veteran; national security and intelligence activities; protective services for the President and others; or a correctional facility if you are an inmate.
   j. Worker's Compensation laws or other similar programs that provide benefits for work related injuries/illnesses.
   k. As required by law.

5. <u>Family/Friends:</u> Under certain circumstances, EOOC may disclose information about you to a family member, a close personal friend or any other individual you identify to EOOC, if disclosure of the medical information is directly relevant to that person's involvement in your medical care and treatment. EOOC may also disclose medical information about you to a family member, a personal representative or another person responsible for your care and treatment in connection with notification to such person of your location, general condition or death. In addition, EOOC may disclose 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.

6. <u>Reminders:</u> EOOC may use and disclose your medical information to provide appointment reminders or information about treatment alternatives or other health related benefits or services that may be of interest to you.

7. **Business Associates:** EOOC may use and disclose certain medical information about you to its business associates. A business associate is an individual or entity under contract with EOOC to perform or assist EOOC in a function or activity which necessitates the use or disclosure of your medical information. Examples include: medical transcriptionists, accountants, lawyers, billing companies, and consultants. EOOC requires that its business associates protect the confidentiality of your medical information.

8. **Other Uses and Disclosures:** Any other uses and/or disclosures if your medical information will be made only with your authorization. Your authorization may be revoked as described but must be communicated in writing.

B. Description of Your Medical Information Rights:

All records created and maintained by EOOC relating to your medical care and treatment are the property of EOOC; however you have the following rights concerning your medical information:

1. **Right to Inspect and Copy:** You have the right to inspect and copy medical and billing records that we maintain, excluding psychotherapy notes. To inspect and/or copy your medical information, you must submit your request in writing to the medical records clerk in our office. Please allow seven to fourteen days, depending on whether or not your chart is in storage. By Oklahoma statute, we currently charge $0.25 per copied page plus postage costs.

2. **Right to an Accounting of Disclosures:** You have the right to request a list of the disclosures we have made of your medical information. To request this list, you must submit your request in writing to the medical records clerk in our office. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request must state in what form you want the list. Each year, the first copy of the list is free, but each additional list may involve a cost.

3. **Right to Amend:** You have the right to request an amendment to the medical information we have about you if you believe it is incomplete or incorrect. To request an amendment, your request must be made in writing; include a reason for your request and be submitted to the privacy officer. We may deny your request for an amendment for the following reasons: it is not in writing; does not include a reason; the information was not created by us; is not a part of the medical information kept by our practice; is not part of the information which you be permitted to inspect or copy; or in our judgment, the information is accurate and complete as it appears or as it was at the time it was originally recorded. A request for an amendment will be acted on no later than sixty days after its receipt.

4. **Right to Request restrictions:** You have the right to request a restriction on the information we use or disclose for treatment, payment or health care operations. However, we must receive your restrictions in writing before disclosure. Also, if you restrict our right to use your medical information for treatment or health care operations, we are not required to agree to the restriction and reserve the right to immediately withdraw our services from you and terminate the physician-patient relationship.

5. **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, only contact you at work, home, by mail, phone, answering machine, etc. Your request must be specific and in writing to the privacy officer in our office.

6. **Right to Receive a Copy of this Notice:** You have the right to receive a paper copy of this Privacy Notice.

C. For More Information or to Report a Problem: If you have questions and would like additional information, you may contact the privacy officer at 6585 South Yale, Tulsa, Oklahoma 74136, (918) 494-9300. If you believe your privacy rights have been violated, you may file a complaint with the EOOC Privacy Officer or with the Secretary of the Department of Health and Human Services. All complaints must be in writing. There will be no retaliation by EOOC, if you file a complaint.

D. Changes to this Notice: EOOC will abide by the terms of this Notice with respect to the manner in which it uses and discloses your medical information. EOOC reserves the right to revise the terms of this notice and to make revised notice provisions effective for all medical information maintained by EOOC. Should EOOC change its policies, you may request a copy of the revised notice provisions from EOOC.

Eastern Oklahoma Orthopedic Center, Inc.
Authorization to Release Medical Information

I hereby authorize ______________________________ to release the following information contained in its records to:
Name:____
Address:____

______________________________ Name of Patient

______________________________ Date of Birth

______________________________ Date of Service

Purpose: 1. Personal Records ____
2. Further Treatment ____
3. Marketing ____
4. Remuneration ____
5. Other __________

This authorization will expire on __________ (consent date or event) or 6 months after the date of signature.

I UNDERSTAND THAT MY MEDICAL RECORDS MAY CONTAIN INFORMATION THAT INDICATES THAT I HAVE A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT IS NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, OR THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNCE DEFICIENCY SYMDROME (AIDS).

1. The type of information to be used or disclosed is as follows (check the appropriate boxes and include other information where indicated.)
   ____ Complete Record
   ____ Pertinent information which includes: Facesheet, Discharge Summary, History & Physical, Physician Orders, Statement of Diagnostic Test Results
   ____ Lab Results
   ____ X-ray and Imaging Reports
   ____ Other (please describe):______________________________
2. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
3. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
4. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

______________________________ Signature of Patient or Legal Representative ______________ Date

If signed by Legal Representative, relationship to patient: ______________

______________________________ Signature of Witness ______________ Date

(If patient is a minor or unable to sign, complete the following)

______________________________ Reason Unable to Sign

______________________________ Signature of Parent, Guardian, or State Relationship