



## **Notice of Privacy Practices**

### **WHAT IS THIS NOTICE OF PRIVACY PRACTICES?**

This notice describes ways in which your medical information may be used and disclosed. This notice also explains *your* rights and the obligations *we* have regarding the use and disclosure of medical information. This notice applies to ALL of your records generated and used by Dermatology Partners of Northern New Mexico, whether made by the practice or another facility. This notice describes our policies which extend to all areas of our practice, all who work for or with our practice, and any business associates involved in the handling of your medical information. Please review carefully.

### **YOUR PERSONAL MEDICAL INFORMATION - "PROTECTED HEALTH INFORMATION" (PHI)**

Your medical/health information is personal, and we are committed to protecting the information about you. At Dermatology Partners of Northern New Mexico, we create paper and electronic records of the care and services/items you receive at our office. We must keep such records to provide you with quality care and to comply with certain legal requirements.

### **OUR OBLIGATIONS REGARDING YOUR PROTECTED HEALTH INFORMATION (PHI)**

By law, we are required to:

- Make sure that your protected health information (PHI) is kept private;
- Provide you with our Notice of Privacy Practices that details how we use and disclose your PHI;
- Advise you of the laws about PHI and your legal rights with respect to your PHI;
- Follow the conditions of the notice that is currently in effect.

Changes to this Notice: We reserve the right to change this notice at any time. We will always have a copy of the current notice available in the office. The notice will contain the date of last revision and effective date on the first page (top right hand corner). Each time you visit the office you may request a copy of the current notice in effect.

Handling of Protected Health Information (PHI): This notice will detail how the law allows us to use and disclose your PHI. Other uses and disclosures of PHI *not* covered by this notice or the laws that apply to us will be made *only with your written permission*. Examples of requests requiring written authorization include release of PHI to:

- Another physician,
- You or a family member,
- A life insurance company.

If you have provided us with your permission to use or disclose your PHI, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose your PHI for the reason covered by your written authorization.

## **HOW WE ARE ALLOWED TO USE & DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI)**

The following categories describe different general ways (with examples) that the law allows us to use and disclose PHI without a special written authorization from you.

- ▶ **Medical Treatment:** We may use your PHI to provide you with medical treatment or services. We may disclose your PHI to other health care professionals who are, were, or may become involved in taking care of you. Examples include sharing your information with: your family doctor that referred you here initially, a friend or family member involved in your care, a doctor we refer you to for a special treatment, or someone who helps pay for your care.
- ▶ **Payment:** We may use and disclose your PHI so that the treatment and services that 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 current or previous health plan information about treatment you received at our office so your plan will pay us for the visit. We may also tell your health plan and/or referring physician about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.
- ▶ **Billing:** We may use and disclose medical information to our electronic billing company who submits our insurance claims to insurance companies electronically. This is necessary because many insurance companies no longer accept "paper claims" and require electronic claims submissions.
- ▶ **Operational Uses:** We do many things that any business would do. We may use and disclose PHI so that we can run our practice more efficiently and make sure that our patients receive quality care. Such uses may include those associated with evaluating the quality of care we give (via internal or external review/audit), training our staff, complying with legal requirements/ lawyers, and other such business operations. When business associates are used, we shall advise them of their continued obligation to maintain the privacy of your medical records.
- ▶ **Appointment, Treatment, Recall Reminders:** We may use and disclose PHI to contact you as a reminder that you have an appointment with us or that you are due for an appointment with us. This contact may be via telephone, e-mail, postcards, or other means and may involve leaving a message on e-mail, voice mail, an answering machine, or with family, etc. Others could pick up such communications.
- ▶ **Marketing/ New and Special Treatments:** We may use and disclose PHI to keep you posted about procedures, treatments, or products that you might find of interest. We may also use PHI to inform you about our upcoming events, seminars, and discounts on products/services.
- ▶ **Pathology / Blood work:** We may use and disclose PHI to diagnostic labs/ pathology labs in order to send specimens and receive results for you.
- ▶ **Laser Services:** If you choose to have laser treatments, we may need to share your medical information with our laser technician
- ▶ **Required By Law:** We will disclose PHI when required to do so by federal, state or local law. We may also release PHI to a law enforcement official to report or solve crimes and in response to a court order, subpoena, warrant, summons, or similar process.
- ▶ **Lawsuits and Disputes:** If you are involved in a lawsuit or a dispute, we may disclose PHI in response to a court or administrative order. We may also disclose PHI in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute. We shall attempt in these cases to tell you about the request, so you may obtain an order protecting the information requested if you so desire. We may also disclose PHI to defend any member of our practice in any actual or threatened action.



## Dermatology Partners of Northern New Mexico, LLC.

### SPECIAL SITUATIONS

▶ To Avert a Serious Threat to Health or Safety: We may use and disclose PHI when necessary to prevent a serious threat either to your specific 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. For example, we may share PHI with federal officials for national security reasons.

▶ Organ and Tissue Donation: If you are an organ donor, we may release PHI to appropriate organizations to facilitate organ or tissue donation and transplantation.

▶ Disaster relief: We may disclose PHI to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

▶ Workers Compensation: We may release PHI for workers compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

▶ Public Health Risks: Law or public policy requires us to disclose medical information about you for public health activities. These activities include the following:

- To prevent or control disease, injury, or disability;
- To report births and deaths;
- To report child abuse or neglect;
- To report reactions to medications or problems with products;
- To notify a people of recalls of products they may be using;
- 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 abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

▶ Investigation and Government Activities: We may disclose PHI to a local, state or federal agency for activities authorized by law. These oversight activities may include audits, investigations, inspections, and licensure. These activities are necessary for the government, health plans, and other regulatory agencies to monitor the health care system, government programs, and compliance with laws.

▶ Coroners, Medical Examiners and Funeral Directors: We may release PHI to a coroner or medical examiner, for example, to help identify a deceased person or determine the cause of death. We may also release PHI to funeral directors as necessary to carry out their duties.

### **PATIENT RIGHTS REGARDING PROTECTED HEALTH INFORMATION (PHI)**

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

◆ **Right to Inspect and Copy:** You have the right to inspect and have copies of your PHI (including medical and billing records but not psychotherapy notes). Upon proof of an appropriate legal relationship, records of others related to you or under your care (guardian or custodial) may also be disclosed.

To inspect and have a copy of your medical record, you must submit your request in writing to Dermatology Partners of Northern New Mexico - Attn: HIPAA Compliance Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies (tapes, disks, etc.) associated with your request. We may deny your request in certain very limited circumstances. If we deny your request, we will explain why, and you may request that the denial be reviewed.



## Dermatology Partners of Northern New Mexico, LLC.

◆ **Right to Amend:** If you feel that the medical information we have about you in your record is incorrect or incomplete, then you may ask us to amend the information, following the procedure below. You have the right to request an amendment for as long as the practice maintains your medical record.

To request an amendment, submit the request in writing to John Bowden MD or Allison Legler MD. You must identify your intended amendment and a reason that supports your request to amend. The information must be dated, signed by you, and notarized.

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;
- Is not part of our records;
- Is not part of the information which you would be permitted to inspect;
- Is accurate and complete.

If we deny amending your PHI, we will tell you why, and we will explain other steps you can take.

◆ **Right to an Accounting of Disclosures:** You have the right to request this “accounting” or list of the disclosures we have made of your PHI to others. The list will *not* include the disclosures detailed above that are allowed by law for purposes of treatment, payment, healthcare operations, public safety, and governmental policy/law enforcement (i.e. those disclosures *not* requiring special authorization from you).

To request this list, you must submit your request in writing to Dermatology Partners of Northern New Mexico – Attn: HIPAA Compliance Officer. You may ask for the “accounting” of those who have seen your PHI in the past 6 years (but we can only give information about the time since June 1, 2017). The first list you request within a twelve (12) month period will be free. For additional lists, we may charge you a fee.

◆ **Right to Request Restrictions:** You have the right to request *in writing* a restriction or limitation on the medical information we use or disclose about you. *We are not required to agree to your request and we may not be able to comply with your request.* For example, you may request a limit on the information we disclose about you to a family member or friend. If we do agree to honor your request, we will comply with your request except in the case of an emergency.

◆ **Right to Request Confidential Communications:** You have the right to request *in writing* that we communicate with you in certain ways or at certain locations. For example, you can ask that we contact you at work instead of home. Or, you may request that we not leave messages on voice mail, e-mail, or the like. We will attempt to accommodate all *reasonable* requests.

◆ **Right to a Paper Copy of This Notice:** You may ask us to give you a copy of this notice at any time.

◆ **Right to Complain:** If you believe your privacy rights have been violated, you may file a complaint with the practice and/or with the Secretary of the Department of Health and Human Services. To file a complaint with the practice, submit your complaint *in writing* to John Bowden MD or Allison Legler MD. All complaints shall be investigated without repercussion to you. You will not be penalized for filing a complaint.

Dermatology Partners of Northern New Mexico provides this Notice to comply with the Privacy Regulations issued by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).



Dermatology Partners of Northern New Mexico, LLC.

## ACKNOWLEDGEMENT OF RECEIPT OF DERMATOLOGY PARTNERS OF NORTHERN NEW MEXICO PRIVACY NOTICE

I have received a copy of Dermatology Partners of Northern New Mexico Notice of Privacy Practices, detailing how my protected health information may be used and disclosed as permitted under federal and state law. The Notice contains a section describing my rights under the law. I have the right to review the Notice before signing this acknowledgement. The terms of the notice may change. If the Notice is revised, I may obtain a revised copy at the office.

I have the right to request restrictions on how protected health information is used or disclosed. The practice is not obligated to agree to such restrictions, but if the practice agrees to any restrictions, it will honor the agreement.

Dermatology Partners of Northern New Mexico MAY release my medical information to the following people or entities: (only provide if applicable)

Name:	Relationship:	Contact Number:
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **Witness:** \_\_\_\_\_

**If not signed by patient, please indicate relationship to patient:** \_\_\_\_\_

\_\_\_\_\_

If a patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document date and time the notice was presented to patient and sign below.

Presented on (date and time): \_\_\_\_\_

By (name and title): \_\_\_\_\_