

# TYLER HEMATOLOGY-ONCOLOGY, P.A.

## Notice of Privacy Practices

For the Athens Clinic, Jacksonville Clinic, and Tyler Clinic

### **PURPOSE:**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. *Please read this notice carefully.* After reviewing this notice you will be asked to consent to the use of your information as described.

### **BACKGROUND:**

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

### **EFFECTIVE DATE:**

This notice takes effect on April 14, 2003, and remains in effect until we replace it.

### **OUR PLEDGE REGARDING MEDICAL INFORMATION:**

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

### **OUR LEGAL DUTY:**

*Law Requires Us to:*

- ☞☞ Keep your medical information private
- ☞☞ Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information
- ☞☞ Follow the terms of the notice that is now in effect.

**TYLER HEMATOLOGY-ONCOLOGY, P.A.**  
**Notice of Privacy Practices**

*We Have the Right to:*

- ✂✂ Change our privacy practices and the terms of this notice at any time, provided the law permits the changes.
- ✂✂ Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the this notice.

This office has policies and procedures in place to facilitate compliance with the law, as well as assure that this office consistently treats you with respect for you and your privacy and confidentiality. These policies and procedures are available for you to review. If you would like to read them please notify the Privacy Officer or the Practice Administrator.

**USE AND DISCLOSURE OF MEDICAL INFORMATION:**

We have a legal, ethical and moral obligation to protect your confidentiality. All employees will hold any information about you and/or your family strictly confidential. No discussions about you outside of the patient care framework will be allowed, and any conversation between staff members that pertains to delivering you quality care will be held in a confidential and professional manner.

In order to provide quality care to you, as well as operate this office in an efficient manner, we will need to access your private health care information for purposes of treatment, payment, and operations (such as quality assurance). In using this information, this office will comply with all state and federal laws pertaining to your privacy rights, including the Privacy and Security protections provided to you by the Health Insurance Portability and Accountability Act ("HIPAA").

Specifically, we will need to disclose your private information under the following circumstances:

***Sharing Information for Purposes of Treatment:*** We will share information with all members of your treatment team, both within this office and with other providers (personal and institutional) in order to provide you with quality care and the educational/wellness programs specified in your insurance plan. We also obtain the right to share information with the Cancer Registry and Tumor Board without patient consent for the purpose of making a treatment decision on behalf of the patient. We will share protected health information for preliminary research (Clinical Trials) for the purpose of developing hypotheses and recruiting research participants without prior patient authorization to determine good candidates for Clinical Trials. Once Clinical Trial candidates have been chosen, patients must sign an authorization from a privacy board or institutional review board allowing the researchers to follow patient progress;

**TYLER HEMATOLOGY-ONCOLOGY, P.A.**  
**Notice of Privacy Practices**

**Sharing of Information for Purposes of Payment:** We will share all necessary information with your insurer(s), payor(s), governmental entities (such as Medicare, Medicaid, etc), and their representatives (including, but not limited to benefit determination and utilization review) as well as our representatives involved in the billing process (including, but not limited to claims representatives, data warehouses, billing companies).

**Sharing of Information for Purposes of Operations:** We will share all information necessary for ongoing operations of this office, including (but not limited to) credentialing processes, peer review, accreditation and compliance with all federal and state laws.

Your consent for use and disclosure of information as described may be revoked in writing at any time. Please notify the office/Privacy Officer if you ever decide to revoke your consent.

Your specific authorization will be required for the release of any information not included above. Your authorization will need to be in writing and it will be specific to the disclosure requested. Incidences, which may require your authorization under HIPAA regulations, include (but are not limited to): some marketing purposes, the disclosure of any psychotherapy records in our possession and disclosures for fundraising by any entity.

This office will not release any information other than those incidents described above; unless, a disclosure is required by law, a court order, a warrant, a subpoena, a summons, a legal process, or government agencies.

**YOUR RIGHTS AS A PATIENT:**

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- ☞☞ The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, closer personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- ☞☞ The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- ☞☞ The right to inspect and copy your protected health information.
- ☞☞ The right to amend your protected health information.
- ☞☞ The right to receive an accounting of disclosures of protected health information.
- ☞☞ The right to obtain and we have the obligation to provide to you a paper copy of this notice from us at your first service delivery date.

TYLER HEMATOLOGY-ONCOLOGY, P.A.  
**Notice of Privacy Practices**

✍✍ The right to provide and we are obligated to receive a written acknowledgement that you have received a copy of Notice of Privacy Practices.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

***QUESTIONS AND COMPLAINTS:***

If you have any questions about this notice, please contact:

CHARLOTTE SCHWIRTZ  
Practice Administrator  
721-A Clinic Drive  
Tyler, Texas 75701  
Telephone: (903) 592-6152

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services  
Office of Civil Rights  
200 Independence Avenue, S. W.  
Washington, D.C. 20201  
Telephone: (202) 619-0257  
Toll Free: 1-877-696-6775

TYLER HEMATOLOGY-ONCOLOGY, P.A.

**Notice of Privacy Practices Acknowledgement Form**

*For the Athens Clinic, Jacksonville Clinic, and Tyler Clinic*

**I have read the NOTICE OF PRIVACY PRACTICES and have had any questions answered by this office. I understand that by signing this form I consent to the following:**

1. **Sharing Information for Purposes of Treatment:** You will share my information with all members of my treatment team, both within this office and with other providers (personal and institutional) in order to provide me with quality care and the educational/wellness programs specified in your insurance plan;
2. **Sharing of Information for Purposes of Payment:** You will share all necessary information with my insurer(s), payor(s), governmental entities (such as Medicare, Medicaid, etc.) and their representatives (including, but not limited to benefit determination and utilization review) as well as your representatives involved in the billing process (including, but not limited to) claims representatives, data warehouses, billing companies);
3. **Sharing of Information for Purposes of Operations:** You will share all information necessary for ongoing operations of this office, including (but not limited to) the credentialing processes, peer review, accreditation and compliance with all federal and state laws.

My consent is freely given. I understand that I may revoke this consent at any time if that revocation is in writing, but any disclosures given in reliance on this prior consent will be permissible.

\_\_\_\_\_  
Patient's Name (printed) Date

\_\_\_\_\_  
Patient's Signature (or guardian, if a minor) Date

\_\_\_\_\_  
Witness (optional) Date

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Initials	Reason