

# Notice of Privacy Practices

*Effective Date: September 23, 2013*

**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.**

If you have any questions about this notice, please contact Sharli Kesecker.  
Pacific Women's OB/GYN Medical Group  
1375 Sutter Street, Suite 105  
San Francisco, CA 94109  
415-379-9600

## **PROTECTED HEALTH INFORMATION:**

In order to treat you, this medical practice obtains and stores health information as part of your medical records and billing records. Generally, health information which can be identified as pertaining to you in particular, by name, address or other identifiers, can be referred to as Protected Health Information.

## **HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:**

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). The medical record is the property of this medical practice, but the information in the records belongs to you. Except for the purposes described below which are permitted by law, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

***For Treatment.*** We use and disclose Health Information to provide you with medical care and related services. We disclose Health Information to our employees and may disclose Health Information to others who are involved in providing you with care. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

***For Payment.*** We use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

***For Health Care Operations.*** We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the medical care you receive is of the highest quality. We

also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

***Appointment Reminders, Sign-In Sheet, Treatment Alternatives and Health Related Benefits and Services.*** We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We may use and disclose Health Information about you by having you sign in when you arrive at our office. We may also call out your name to tell you when we are ready to see you. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

***Business Associates.*** We may disclose Health Information to our business associates who perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. Our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

### **SPECIAL SITUATIONS:**

***As Required by Law.*** We will disclose Health Information when required to do so by international, federal, state or local law.

***To Avert a Threat to Health or Safety.*** We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

***Organ and Tissue Donation.*** If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

***Public Health Risks.*** We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will make this disclosure if you agree, or when required or authorized by law.

***Health Oversight Activities.*** We may disclose Health 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 laws.

***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.

***Lawsuits and Disputes.*** If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information 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, and sometimes are requested by law, to disclose your Health Information to a law enforcement official for purposes such as identifying or locating a missing person or a suspect, fugitive, material witness, or complying with a court order, warrant, subpoena or other law enforcement purposes.

***Coroners, Medical Examiners and Funeral Directors.*** We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

***Specialized Government Functions.*** We may disclose your Health Information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their custody.

***Military and Veterans.*** If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

***Workers' Compensation.*** We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

***Change of Ownership.*** In the event that this medical practice is sold or merged with another organization, your Health Information will be disclosed to the new owner and your record would become the property of the new owner. You would continue to have the right to request that copies of your Health Information be provided to another physician or medical practice.

***Research.*** Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

***Individuals Involved in Your Care or Payment for Your Care.*** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify,

your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

***Individuals Involved in Your Care or Payment for Your Care.*** When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

***Disaster Relief.*** We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

***Fundraising.*** We may use or disclose your demographic information and that dates that you received treatment in or der to contact you for fundraising activities. If you do not want to receive these materials, please contact us at the address given on page 1 of this Notice and we will stop sending any further fundraising communications.

### **YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES**

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

***Psychotherapy Notes.*** Uses and disclosures of psychotherapy notes, although we may disclose Health Information in response to a court or administrative order.

***Marketing.*** Uses and disclosures of Protected Health Information for marketing purposes; and

***Sale of PHI.*** Disclosures that constitute a sale of your Protected Health Information

***Other Uses.*** Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

### **YOUR RIGHTS:**

You have the following rights regarding Health Information we have about you:

***Right to Inspect and Copy.*** You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information,

you must make your request, in writing, to this practice. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

***Right to an Electronic Copy of Electronic Medical Records.*** If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

***Right to Get Notice of a Breach.*** You have the right to be notified of a breach of your unsecured Protected Health Information.

***Right to Amend.*** If you feel that Health Information we have 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 or for our office. To request an amendment, you must make your request, in writing, to this practice at the address noted on page 1.

***Right to an Accounting of Disclosures.*** You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to this practice at the address noted on page 1.

***Right to Request Special Privacy Protections.*** You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to this practice at the address noted on page 1. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us “out-of-pocket” in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

***Out-of-Pocket-Payments.*** If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

***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 by mail or at work. We will accommodate all reasonable requests which are submitted in writing and which specify how or where you wish to receive these communications

***Right to a Paper Copy of This Notice.*** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, please ask at the reception desk or write to us at the address noted on page 1.

### **CHANGES TO THIS NOTICE:**

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

### **COMPLAINTS:**

If you believe your privacy rights have been violated, you may file a complaint with our office and please, write to us at the address noted on page 1.

You have the right to file a Complaint with the Secretary of the Department of Health and Human Services, Office of Civil Rights. The San Francisco Branch is located at 90 Seventh Street, Suite 4-100, San Francisco, CA. or you may use the Department's Complaint Portal, found at: [https://ocrportal.hhs.gov/ocr/cp/complaint\\_frontpage.jsf](https://ocrportal.hhs.gov/ocr/cp/complaint_frontpage.jsf)

**You will not be penalized for filing a complaint.**

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Pacific Women's OB/GYN Medical Group  
1375 Sutter Street, Suite 105  
San Francisco, CA 94109  
415-379-9600

I received a copy of this medical practice's Notice of Privacy Practices. I understand that a copy of the current privacy notice will be posted in the reception area and that a copy of any updated or amended Notice of Privacy Practices will be available at each appointment.

Dated: \_\_\_\_\_ Signed: \_\_\_\_\_

If signed by Parent, Guardian or Conservator,  
please indicate name and relationship to patient: \_\_\_\_\_

Print Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State and Zip Code: \_\_\_\_\_

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