HIPAA Notice of Privacy Practices

Physicians Alliance of Connecticut, (PACT) LLC

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.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected Health Information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

OUR RESPONSIBILITIES TO YOU

We are required by law to:

1. Maintain the privacy of your health information and to provide you with notice of our legal duties and privacy practices.
2. Comply with the terms of our current Notice effective November 1, 2015.

We reserve the right to change our practices and to make the new provisions effective for all health information we maintain. Should we make material changes, revised notices will be made by posting in the various PACT offices and will be available on PACT’s website. Copies of the revised notices may be obtained from the Privacy/Compliance Officer, Yvette Barchat, who can be reached at (203) 643-9703.

OUR USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician’s practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be shared if a doctor treating you for an injury asks another doctor about your overall health condition.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that

your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

***Healthcare Operations*:** We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. Other examples of when your protected health information may be disclosed for healthcare operations include:

- Help train medical students;
- Evaluate the performance of our staff;
- Assess the quality of care and outcomes in your case and similar cases;
- Learn how to improve our facilities and services; and
- Determine how to continually improve the quality and effectiveness of the health care we provide.

OTHER USES AND DISCLOSURES WE MAY MAKE WITHOUT YOUR WRITTEN AUTHORIZATION

1. **Appointments**. PACT may use your information to call, send letters, or postcards to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual. You may request, in writing, that PACT not use one or more of those methods for providing appointment reminders.

2. **Required by Law**. PACT may use and disclose information about you as required by law. Under the law, we must disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

3. **Persons Involved in Your Care or Payment for Your Care**. Unless you object, we may disclose health information about you to a family member, close personal friend or other persons you identify who are involved in your care. These disclosures are limited to information relevant to the person's involvement in your care or in arranging payment for your care.

4. **Public Health Activities**. We may disclose your health information for public health activities.

5. **Reporting Victims of Abuse, Neglect or Domestic Violence**. If we believe that you have been a victim of abuse or neglect, we may disclose your health information to notify a government authority.

6. **Health Oversight Activities**. We may disclose your health information to a health oversight agency for activities authorized by law. A health oversight agency is a state or federal agency that oversees the health care system. Some of the activities may include, for example, audits, investigations, inspections and licensure actions.

7. **Judicial and Administrative Proceedings**. We may disclose your health information in response to a court or administrative order. We also may disclose information in response to a subpoena, discovery request, or other lawful process.

8. **Law Enforcement**. We may disclose your health information for certain law enforcement purposes, including, for example, to file reports required by law or to report emergencies or suspicious deaths; to comply with a court order, warrant, or other legal process; to identify or locate a suspect or missing person; or to answer certain requests for information concerning crimes.

9. **Coroners, Medical Examiners, Funeral Directors, Organ Procurement Organizations**. We may release your health information to a coroner, medical examiner, funeral director and, if you are an organ donor, to an organization involved in the donation of organs and tissue.

10. **To Avert a Serious Threat to Health or Safety**. When necessary to prevent a serious threat to your health or safety, or the health or safety of the public or another person, we may use or disclose your health information to someone able to help lessen or prevent the threatened harm.

11. **Military and Veterans**. If you are a member of the armed forces, we may use and disclose your health information as required by military command authorities.

12. **National Security and Intelligence Activities; Protective Services for the President and Others**. We may disclose health information to authorized federal officials conducting national security and intelligence activities or as needed to provide protection to the President of the United States, certain other persons or foreign heads of states or to conduct certain special investigations.

13. **Inmates/Law Enforcement Custody**. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose your health information to the institution or official for certain purposes including your own health and safety as well as that of others.

14. **Workers' Compensation**. We may use or disclose your health information to comply with laws relating to workers' compensation or similar programs.

15. **Disaster Relief**. We may disclose health information about you to an organization assisting in a disaster relief effort.

16. **Treatment Alternatives and Health-Related Benefits and Services**. We may use or disclose your health information to inform you about treatment alternatives and health-related benefits and services that may be of interest to you.

17. **Business Associates**. We may disclose your health information to our business associates under a Business Associate Agreement.

18. **Research**. PACT may use your health information for research purposes when an institutional review board or privacy board that has reviewed the research proposal established protocols to ensure the privacy of your health information has approved the research.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR ALL OTHER USES AND DISCLOSURES

We will obtain your written authorization (an "Authorization") prior to making any use or disclosure other than those described above. An Authorization is designed to inform you of a specific use or disclosure other than those set forth above that we plan to make of your health information. The authorization describes the particular health information to be used or disclosed and the purpose of the use or disclosure. Where applicable, the written authorization will also specify the name of the person to whom we are disclosing the health information. The authorization will also contain an expiration date or event.

Without your authorization, we are expressly prohibited from using or disclosing your protected health information for the following:

- **Marketing purposes**.
- **Sale of your information**. We may not sell your protected health information without your authorization.
- **Psychotherapy Notes**. We may not use or disclose most psychotherapy notes contained in your protected health information.

In the case of **fundraising**: We may contact you for fundraising efforts, but you will have the opportunity to opt out of receiving such communications.

You make revoke a written Authorization previously given by you at any time but you must do so in writing. If you revoke your Authorization, we will no longer disclose your health information for those purposes specified in the Authorization except where we have already taken actions in reliance on your Authorization.

SPECIAL REGULATIONS REGARDING DISCLOSURE OF MENTAL HEALTH AND HIV-RELATED INFORMATION

For disclosures concerning certain health information such as HIV-related information or records regarding mental health treatment, special restrictions apply. Generally, we will disclose such information only with an Authorization from you, or as otherwise required by law.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

1. **You have the right to inspect and copy your protected health information**. Pursuant to your written request**,** you have the right to inspect or copy your protected health information whether in paper or electronic format. We may charge a reasonable, cost-based fee. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

2. **You have the right to request a restriction of your protected health information**. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

3. **You have the right to request to receive confidential communications**. You have the right to request confidential communication from us by alternative means or at an alternative location. You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will accommodate all reasonable requests.

4. **You have the right to request an amendment to your protected health information**. You have the right to request that we amend your health information. Your request must be made in writing and must state the reason for the requested amendment. We may deny your request for amendment under certain circumstances. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

5. **You have the right to receive an accounting of certain disclosures**. You have the right to receive an accounting of certain disclosures, paper or electronic. An accounting is a listing of disclosures made by us or on our behalf, but does not include specific categories of disclosures not required to be contained in an accounting including those made for treatment, payment or health care operations, and other certain disclosures (such as any you asked us to make). We will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another within 12 months.

6. **You have the right to obtain a paper copy of this notice**. You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

7. **You have the right to choose someone to act for you**. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

8. **Notification of Breaches of Your Health Information.** You have the right to receive written notification of any "breach" of your unsecured protected health information, as that term is defined in 45 CFR §164.402.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance/Privacy Officer of your complaint.

Compliance/Privacy Officer
Physician Alliance of Connecticut
322 E Main St, Suite 1B,
Branford, CT 06405
Telephone: (203) 643-9703
Email: compliance@pactmd.com

You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**

We will not retaliate against you for filing a complaint against PACT.

QUESTIONS

If you have any questions in reference to this form, please ask to speak with our Compliance/Privacy Officer, Yvette Barchat, in person or by phone at (203) 643-9703.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: ___________________________________ DOB: ___________________

Address:
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I have been given a copy of PACT, LLC *Notice of Privacy Practices*, which describes how my health information is used and shared. I understand that PACT, LLC has the right to change this *Notice* at any time. I may obtain a current copy by contacting the Privacy Official at 322 East Main Street, Suite 1B, Branford, CT 06405.

My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices:*

____ ____________________
Signature of Patient or Guardian   Date

____
Print Name

For Facility Use Only: Complete this section if you are unable to obtain a signature.
1. If the patient or guardian is unable or unwilling to sign this *Acknowledgement*, or the *Acknowledgement* is not signed for any other reason, state the reason:

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2. Describe the steps taken to obtain the patient's (or guardian's) signature on the *Acknowledgement:*

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Completed by:

_____________________________________ ___________________________
Signature of Staff Member   Date

____
Print Name