SOUTH VALLEY VASCULAR ASSOCIATES, INC.

HIPAA and Notice of Privacy Practices

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!

We are required by law to keep your protected health information confidential. Authorization for the disclosure of your protected health information to someone who is not legally required to keep it private may cause the information to no longer be protected by state and federal confidentiality laws. In accordance with state and federal patient privacy laws, including HIPPA (the Health Insurance Portability and Accountability Act of 1996), this Notice describes how your protected health information may be used or disclosed and how you, the patient, can get this information. Please review this Notice carefully.

DEFINITION OF "PROTECTED HEALTH INFORMATION": Your "protected health information" is health information about you, which someone may use to identify you, and which we keep or transmit in electronic, oral, or written form. It includes information about your name; contact information; past, present, or future physical or mental health or medical conditions; payment for health care products or services, and/or prescriptions.

PERMITTED USES & DISCLOSURES: The law permits us to use or disclose your protected health information to the following. Note: This is a non-exhaustive list.

- Another specialist or physician who is involved in your care.
- Coroners, medical examiners, or funeral directors when an individual dies.
- Your insurance company, for the purpose of obtaining payment for our services.
- Our staff, for the purpose of entering your information into our computerized system.
- To run our practice, improve your care, and contact you when necessary (e.g., to manage the services and treatment you receive or to monitor the quality of our health care services).
- To outside persons or entities that perform services on our behalf, such as auditing, legal, or transcription ("business associates"). The law requires our business associates and their subcontractors to protect your protected health information in the same way we do. We also contractually require these parties to use and disclose your protected health information only as permitted and to appropriately safeguard your protected health information.
- Other entities during the course of your treatment, in order to obtain authorizations, referral visits, scheduling of tests, etc. Much of this information is sent via fax which is a permitted use allowed by law. We have on file with these sources, verification for the confidentiality of the fax used and its limited access by authorized personnel.
- If this practice is sold, your protected health information will become the property of the new owner.
- We may release some or all of your protected health information when required by law (e.g., responding to a court or administrative order or subpoena, discovery request, etc.). Except as described above, this practice will not use or disclose your protected health information without your prior written authorization.
- We may use and disclose your protected health information to address and respond to workers' compensation or other government requests.
- We may share your protected health information to report injuries, births, and deaths; prevent disease; report adverse reactions to medications or medical device product defects; report suspected child neglect or abuse, or domestic violence; and/or avert a serious threat to public health or safety.
- For organ and tissue donation requests.
- We may share your protected health information for some types of health research.

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Federal and state law allows us to use and disclose our patients' protected health information in order to provide health care services to them, to bill and collect payments for those services, and in connection with our health care operations. We also use a shared Electronic Medical Record that allows both our physicians and staff access to our patients' protected health information. The purpose for this access is to expedite the referral of patients within the BASS Medical Group, other providers, and to assist in providing and managing their care in a coordinated way.

Information in the Electronic Medical Record can be released outside the BASS Medical Group only with the patient's express authorization or as otherwise specifically permitted or required by law.

PATIENT RIGHTS: The law also establishes patient rights and our responsibility to inform you of those rights. These include:

- You have the right to request in writing any uses or disclosures we make with your protected health information beyond the normal uses referenced above.
- You have the right to limit the use or restrict the use disclosure of your protected health information. Our office will follow any restrictions notated by you on page 2 of this Form.
- You have the right to request in writing to inspect and/or receive a copy of your protected health information.* Our office may charge a reasonable fee to cover copying and mailing of these records to you. Some releases of your protected health information may require the completion and submission of a separate request or form from this one, as our Privacy Officer may determine.
- You have the right to request an alternate means or location to receive communications regarding your protected health information.* Otherwise, such communications will be mailed to the home address in your medical or billing record and/or sent to the alternative address and/or by the alternative means of communication(s) you designate below (E.g., via telephone text or email).
- You have the right to request in writing an amendment or change to your protected health information. Our office may agree or disagree with your written request, but we will be happy to include your statement as part of your records. If an agreement to amend or change is acceptable, please be advised that previous documentation is considered a legal document and cannot be deleted or removed. Our office will simply notate the amendment and the reason for it and add it to your records.

  * Conditions and limitations may apply; obtain additional information from our Privacy Officer.
- We may use your information to contact you. For example, we may use the U.S. Mail, the telephone, a Text message, or email to remind you of an appointment or call you with information regarding your care. If you are not at home, this information may be left on your answering machine, voicemail, sent via Text, via email, or with the person who answered the phone. In an emergency, we may disclose your protected health information to a family member or another person designated responsible for your care.
- **MINORS**: We take patient privacy laws very seriously. **The State of California** limits what type of health information we can share with the parents or legal guardians of **minor** teenage children between the ages of 12 and 17. Accordingly, we will maintain an exclusive phone number and/or email address for **minors** in this age range, as they may designate.

  IF PATIENT IS A MINOR, PLEASE STATE AGE: _____ AND DATE OF BIRTH: _____
- **WHOM I DESIGNATE: Please designate who our offices CAN disclose your protected health information to, including, but not limited to correspondence, test results, prescriptions, medical records, or billing information, who are 18 years or older, by checking the boxes below and signing below:**

  This authorization to Release Protected Health Information is voluntary.

  ☐ **OK to Spouse: Please list name, alternative address, phone number, and email addresses of Family Member(s), as applicable:**

☐ **OK to Other (e.g. Attorney, Accountant, Financial Advisor, Power of Attorney, Legal Guardian, Conservator, or other legally authorized agent or representative). Please list name(s), alternative address, phone number, and email addresses of authorized personnel or entities:**

☐ **OK to leave protected health information on answering machine, voicemail, telephone, text, or email.**

☐ **DO NOT RELEASE AND SEND ANY INFORMATION to anyone other than myself (the Patient). Please send my information to my home address or the alternative address, phone number, and email address I list here:**

Address: _____ **Phone:** _____ **Email address:** _____

_____ **IF PATIENT IS A MINOR, PLEASE STATE AGE:** ____ **AND DATE OF BIRTH:** _____

☐ DO NOT RELEASE TO: _____

(Please list names, as applicable)

PATIENT CHOICES: For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, please contact our Office at (559) 625-4118 who will make reasonable efforts to follow your instructions.

In these cases, you have both the right and choice to tell us whether to:

- Share information with your family, close friends, or others involved in your care.
- Share information in a disaster relief situation.

If you are unable to tell us your preferences, we may share your information if we believe it is in your best interest according to our best judgment. We may also share your information when needed to lessen a serious and imminent threat to health and safety.

In these cases, we will not share your information unless you give us written permission:

- Marketing purposes.
- Other uses and disclosures not described in this Notice.

You may revoke your authorization at any time, but it will not affect information that we already used and disclosed.

We will promptly notify you if a data breach occurs that may have compromised the privacy or safety of your protected health information. We reserve the right to change our privacy practices and the conditions of this notice at any time and without prior notice. In the event of changes, an updated notice will be posted and our

office will notify you of the changes in writing. You have the right to file a complaint with the Department of Health and Human Services, 200 Independent Avenue, S.W., Room 509F, Washington, DC 20201. Our office will not retaliate against you for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your protected health information privacy, please contact our office at 559-625-4118.

ACKNOWLEDGEMENT, AUTHORIZATION, & CONSENT

This acknowledges that you have received arid read a copy of our HIPAA Privacy Practices Notice and Consent to the use and disclosure of your protected health information to the person(s) or entities you have designated above. This document will remain as part of your medical and billing record.

Signature: _____ Date:

_____ Patient's Name:

_____ Date of Birth:

_____

If person signing is not patient, please provide name and identify the relationship to the patient and in what capacity you/they are signing (E.g., parent, guardian, conservator):

Name:

_____

Capacity and/or Relationship to patient:

_____

This authorization/consent may be revoked at any time prior to the release of the requested information. The revocation must be in a writing, signed by the patient or their authorized representative, and delivered to BASS at their address referenced below.

Patient's authorized representative is entitled to receive a copy of this Authorization.

EXPIRATION OF AUTHORIZATION/CONSENT: Unless otherwise revoked, rescinded, revised, updated, or changed by you in a writing signed by you, this Authorization & Consent shall not expire and will last indefinitely.