

Southern Illinois Dermatology

Notice of Privacy Practice

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 practice creates a medical record of your health information in order to treat you, receive payment for services delivered, and to comply with certain policies and laws. We are also required by law to provide you with this Notice of our legal duties and privacy practices. In addition, the law requires us to ask you to sign an Acknowledgment that you received this Notice.

We are required by federal and state law to maintain the privacy of your medical information. Medical information is also called “protected health information” or “PHI.” We are also required by law to notify you if you are affected by a breach of your unsecured PHI.

This is a list of some of the types of uses and disclosures of PHI that may occur:

Treatment: We obtain health information, or PHI, about you to treat you. Your PHI is used by us and others to treat you. We may also send your PHI to another physician, facility, or counselor to which we refer you for treatment, care, procedures, or testing. We may also use your PHI to contact you to tell you about alternative treatments, or other health-related benefits we offer as well as appointment reminders and other health related information regarding your care and treatment. This may include leaving messages at phone numbers your included on your patient registration. If you have a friend or family member involved in your care, we may give them PHI about you.

Payment: We use your PHI to obtain payment for the services that we render. For example, we send PHI to Medicaid, Medicare, or your insurance plan to obtain payment for our services.

Health Care Operations: We use your PHI for our operations. For example, we may use your PHI in determining whether we are giving adequate treatment to our patients. From time-to-time, we may use your PHI to contact you to remind you of an appointment.

Legal Requirements: We may use and disclose your PHI as required or authorized by law. For example, we may use or disclose your PHI for the following reasons:

Public Health: We may disclose your health information to prevent or control disease, injury or disability, to report births and deaths, to report reactions to medicines or medical devices or to report suspected cases of abuse or neglect.

Health Oversight Activities: We may use and disclose your PHI to state agencies and federal government authorities when required to do so. We may use and disclose your health information in order to assist others in determining your eligibility for public benefit programs and to coordinate delivery of those programs. For example, we must give PHI to the Secretary of Health and Human Services in an investigation into our compliance with the federal privacy rule.

Judicial and Administrative Proceedings: We may use and disclose your PHI in judicial and administrative proceedings. Efforts may be made to contact you prior to a disclosure of your PHI to the party seeking the information.

Law Enforcement: We may use and disclose your PHI in order to comply with requests pursuant to a court order, warrant, subpoena, summons, or similar process. We may use and disclose PHI to locate someone who is missing, to identify a crime victim, to report a death, to report criminal activity at our offices, or in an emergency.

Avert a Serious Threat to Health or Safety: We may use or disclose your PHI to stop you or someone else from getting hurt.

Work-Related Injuries: We may use or disclose PHI to an employer if the employer is conducting medical workplace surveillance or to evaluate work-related injuries.

Coroners, Medical Examiners, and Funeral Directors: We may use or disclose PHI to a coroner or medical examiner in some situations. For example, PHI may be needed to identify a deceased person or determine a cause of death. Funeral directors may need PHI to carry out their duties.

Armed Forces: We may use or disclose the PHI of Armed Forces personnel to the military for proper execution of a military mission. We may also use and disclose PHI to the Department of Veterans Affairs to determine eligibility for benefits.

National Security and Intelligence: We may use or disclose PHI to maintain the safety of the President or other protected officials. We may use or disclose PHI for the conduct of national intelligence activities.

Correctional Institutions and Custodial Situations: We may use or disclose PHI to correctional institutions or law enforcement custodians for the safety of individuals at the correctional institution, those that are responsible for transporting inmates, and others.

Research: You will need to sign an Authorization form before we use or disclosure PHI for research purposes except in limited situations. For example, if you want to participate in research or a clinical study, an Authorization form must be signed.

Fundraising/Marketing: We do not engage in fundraising activities. We do not engage in marketing activities, and need your authorization to do so.

Immunizations: If we obtain and document your verbal or written agreement to do so, we may release proof of immunization to a school where you are a student or prospective student.

Illinois law: Illinois law also has certain requirements that govern the use or disclosure of your PHI. In order for us to release information about mental health treatment, genetic information, your AIDS/HIV status, and alcohol or drug abuse treatment, you will be required to sign an Authorization form unless state law allows us to make the specific type of use or disclosure without your authorization.

Your Rights: You have certain rights under federal and state laws relating to your PHI. Some of these rights are described below:

Restrictions: You have a right to request restrictions on how your PHI is used for purposes of treatment, payment and health care operations. We are not required to accommodate to your request, except as required by law. The practice is required to comply with your request for restrictions on the use or

disclosure of your PHI to health plans for payment or health care operations purposes when the practice has been paid out of pocket in full and the practice has been notified of the request for restriction in writing, and the disclosure is not required by law. If you do not specifically request in writing a restriction for PHI that has been paid out of pocket in full, the practice may release that information.

Communications: You have a right to receive confidential communications about your PHI. For example, you may request that we only call you at home. If your request is reasonable, it may be accepted.

Inspect and Access: You have a right to inspect your health information. This information includes billing and medical record information. You may not inspect your record in some cases. If your request to inspect your record is denied, we will send you a letter letting you know why and explaining your options.

You may have a paper or electronic copy of your PHI in most situations. If you request a copy of your PHI, we may charge you a fee for making the copies and mailing them to you, if you ask us to mail them.

Amendments of Your Records: If you believe there is an error in your PHI, you have a right to request that we amend your PHI. We are not required to agree with your request to amend.

Accounting of Disclosures: You have a right to receive an accounting of disclosures that we have made of your PHI for purposes other than treatment, payment, and health care operations, or release made pursuant to your authorization.

Copy of Notice: You have a right to obtain a paper copy of this Notice, even if you originally received the Notice electronically. We have also posted this Notice at our offices.

Complaints: If you feel that your privacy rights have been violated, you may file a complaint with us by calling our Privacy Officer at 618-942-3344. We will not retaliate against you for filing a complaint. You may also file a complaint with the Secretary of Health and Human Services in Washington, DC if you feel your privacy rights have been violated.

Authorizations: We are required to obtain your written Authorization when we use or disclose your PHI in ways not described in this Notice or when we use or disclose your PHI as follows: for marketing purposes, for the sale of your PHI, or for uses and disclosures of psychotherapy notes (except certain uses and disclosures for treatment, payment, or health care operations). You may revoke your Authorization at any time in writing, except to the extent that we have already acted on your Authorization.

We are required to abide with terms of the Notice currently in effect, however, we may change this Notice. If we materially change this Notice, you can get a revised Notice on our website at www.vanackerdermatology.com or by stopping by our office to pick up a copy. Changes to the Notice are applicable to the health information we already have.

EFFECTIVE DATE: September 1, 2013

Southern Illinois Dermatology
Acknowledgement of Privacy Notice

I have received for review the Notice of Privacy Practices. I understand that this Notice of Privacy Practices describes the types of uses and sharing of my protected health information that will occur in my treatment, payment of my bills, or in the health care operations of Southern Illinois Dermatology and my rights as they relate to the privacy of my health information. I understand that I may request and will receive a copy of the Notice of Privacy Practices.

Signature of Patient or Personal Representative

Today's Date

Printed Name of Patient or Personal Representative

Patient Name if signed by Personal Representative

Patient's Date of Birth

Description of Personal Representative's Authority

Authorization for Designated PHI Recipient

I, _____ give permission to Southern Illinois
(Patient's Printed Name)
Dermatology to release my Protected Health Information (PHI) to:

RECIPIENT NAME:	DOB:	RELATIONSHIP:	PHONE NUMBER:
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

I understand that this authorization is valid indefinitely unless I notify Southern Illinois Dermatology that I wish to revoke the authorization.

Patient Signature

Date

Patient's Date of Birth