

# DERMATOLOGY MEDICAL ASSOCIATES

## NOTICE OF PRIVACY PRACTICES

### THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THE INFORMATION.

PLEASE REVIEW IT CAREFULLY. THIS NOTICE IS REQUIRED UNDER FEDERAL MANDATE OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

#### USES AND DISCLOSURES

**TREATMENT.** Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. Results will be available in your medical record to all health professionals who may provide or who may be consulted by our physicians and staff.

**PAYMENT.** Your health information may be used to seek payment from your health plan. Your health plan may request and receive information on dates of service, the services provided and the medical condition being treated.

**HEALTH CARE OPTIONS.** Your health information may be used as necessary to support the day to day activities and management of DMA. Information on the services you received may be used to support budgeting and financial reporting, activities to evaluate and promote quality.

**LAW ENFORCEMENT.** Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

**PUBLIC HEALTH REPORTING.** Your health information may be disclosed to public health agencies as required by law. We are required to report certain communicable diseases to the state's public health department.

**APPOINTMENT REMINDERS.** Your health information may be used or disclosed to provide a reminder to you about an upcoming appointment.

**WORKERS COMPENSATION.** Your health information may be used or disclosed in order to comply with laws and regulations related to workers compensation.

**TREATMENT OPTIONS.** Your health information may be used to send you information regarding new treatment or management options for your medical condition.

**OTHER USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION.** Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

### **INDIVIDUAL RIGHTS.**

- The right to request restrictions on the use and disclosure of your protected health information (Dermatology Medical Associates is not required to honor, and withholds the right to deny, any such request).
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed (such an accounting will not include disclosures for treatment, payment, health care operations and disclosures made based upon an authorization).
- The right to receive a copy of this notice.

**RIGHT TO REVISE PRIVACY PRACTICES.** As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may require by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

**REQUESTS TO INSPECT PROTECTED HEALTH INFORMATION.** As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our front office staff or our privacy officer. We may charge you a reasonable fee for copying and mailing of protected health information.

**DERMATOLOGY MEDICAL ASSOCIATES DUTIES.** We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

**CONTACT OR COMPLAINTS.** If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

**Wendy Wilkie Dermatology Medical Associates 1363 7<sup>th</sup> Ave East Hendersonville, NC 28792**

If you believe that your privacy rights have been violated you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You may also send a written complaint to the US Secretary of the Department of Health and Human Services. You will not be penalized or otherwise retaliated against for filing a complaint.

**EFFECTIVE DATE: THIS NOTICE IS EFFECTIVE ON OR AFTER APRIL 14<sup>TH</sup> , 2003.**

**1363 7<sup>th</sup> Ave East Hendersonville, NC 28792**