

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

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.

I. Use and Disclosures

- A. We may use or disclose your protected health information without your written consent, written authorization or oral agreement for the following purposes.**

Treatment. Example: We may use your health information within our office to provide health care services to you or we may disclose your health information to another provider if it is necessary to refer you to them for services.

Payment. Example: Unless you request otherwise, we may use or disclose health information to a family member, friend, or other personal representative to the extent necessary to help with your healthcare or with payment for your health care. In addition, we may use your confidential information to remind you of appointments by sending reminder postcards and/or leaving messages at home and/or work. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Health Care Operations. Example: Health Care Operations include the business aspects of running our practice. For example, patient information may be used for training purposes, or quality assessment.

- B. We may use or disclose your protected health information without your written consent, written authorization or oral agreement under the following circumstances:**

- **If we provide services to you in an emergency treatment situation.**
- **If we are required by law to provide services to you and we were unable to obtain your consent after attempting to do so.**
- **If there are substantial barriers to communication and we determine, in the exercise of our professional judgment, that you intend for us to treat you.**
- **If we need to notify, or assist in the notification of, a family member, personal representative or another person responsible for your care or your location, general condition or death.**
- **If we are required by law to disclose your health information to a public health authority that is authorized to receive information for the purposes of preventing or controlling disease, injury or disability.**
- **If we are required by law to disclose your health information to a public health or other government authority that is authorized to receive reports of child abuse or neglect.**
- **If we are required to disclose your health information to the Food and Drug Administration.**

- If we are required to disclose your health information to your employer to evaluate whether you have a work-related injury or illness.
- If we are required by law to disclose your health information to a government authority authorized to receive reports of abuse, neglect, or domestic violence.
- If we are required to disclose your health information to a health oversight agency for oversight activities required by law.
- If we are required to disclose your health information in response to a court order or a subpoena.
- If we are required to disclose your health information to a law enforcement official.
- If we are required to disclose your health information to a coroner, medical examiner or funeral director.
- For research purposes
- If we, in good faith, believe that the use of disclosure of your health information is necessary to prevent a serious threat to the health or safety of others.
- If we are authorized by law to disclose your health information to comply with laws established to provide benefits of work-related injuries or illnesses.

WITH THE EXCEPTION OF THE ABOVE CIRCUMSTANCES, ANY USE OF DISCLOSURE OF YOUR HEALTH INFORMATION WILL BE MADE ONLY WITH YOUR WRITTEN AUTHORIZATION. YOUR WRITTEN AUTHORIZATION MAY BE REVOKED, IN WRITING, AT ANY TIME EXCEPT TO THE EXTENT THAT WE HAVE PROVIDED SERVICES OR TAKEN ACTION IN RELIANCE ON YOUR AUTHORIZATION

II. Your Rights

Right to Request Restrictions. You have the right to request restrictions on certain uses and disclosures of your health information. However, we are not required to agree to the requested restrictions. Your request to limit the use and/ or disclosure of your health information must be made in writing to your Case Manager.

Right to Receive Confidential Communications. You have the right to receive confidential communications concerning your health information. Your request to receive confidential communications must be made in writing to your Case Manager. We will accommodate all reasonable requests by you to receive your health information at a place other than your home address or by means other than regular mail.

Right to Inspect and/or Copy. You have the right to inspect and/or copy certain health information for as long as that information remains in your record. Your request to inspect and/or copy your health information must be made in writing to your Case Manager.

Right to Amend. You have the right to request that we amend certain health information for as long as that information remains in your record. Your request to amend your health information must be made in writing to your Case Manager and you must provide a reason to support the requested amendment.

Right to Receive an Accounting. You have the right to receive an accounting of our disclosures of your health information made six years prior to the date of your request. We will provide you with the first accounting in any 12 month period at no charge. There will be a fee charged for any subsequent request. Your request to receive an accounting must be made in writing to your Case Manager. The Accounting will not include the following disclosures:

Disclosures made to carry out treatment, payment and health care operations;
Disclosures made to you;
Disclosures made in our facility directory;
Disclosures made to individuals involved with your care;
Disclosures made for national security or intelligence purposes;
Disclosures made to correctional institutions or law enforcement offices; and
Disclosures made prior to the compliance date of the HIPPA Privacy Rule.

Right to Receive Notice. You have the right to receive a paper copy of this Notice, upon request.

III. Our Duties

We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to your protected health information.

We must abide by the terms of this Notice while it is in effect. However, we reserve the right to change the terms of the Notice and make the new notice provisions effective for all of the protected health information that we maintain. If we make a change in the terms of this Notice, we will notify you in writing and provide you with a paper copy of the new notice, upon request.

IV. Complaints

If you believe your privacy rights have been violated, you may file a complaint with Pine Tree Clinic for Comprehensive Medicine or with the Secretary of the Department of Health and Human Services, 200 Independence Avenue, SW, Washington, DC 20201, (877) 696-6775 (toll free). To file a complaint with Pine Tree Clinic for Comprehensive Medicine, contact our Privacy Officer, who will direct you on how to file an office complaint. All complaints must be submitted in writing, and all complaints shall be investigated without repercussion to you. You will not be penalized for filing a complaint.

V. How to Contact Us

If you would like further information about our privacy practices, please contact:

Pine Tree Clinic for Comprehensive Medicine
843 Miller Valley Road, Suite 204
Prescott, AZ 86301
(928) 778-3500
Robert Zieve, MD, MD(H)

Effective Date of this Notice: June 1, 2004