

# MOREHOUSE MEDICAL ASSOCIATES

**POLICY:** PROVISION OF NOTICE OF PRIVACY PRACTICES (NOPP)

**SUBJECT:** HEALTH INFORMATION MANAGEMENT

**POLICY #:** 0018

**EFFECTIVE DATE:** April 14, 2003

## **PURPOSE:**

To establish policy and procedure for the provision of the Notice of Privacy Practices as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

## **ACCOUNTABILITY:**

The Medical Director shall ensure compliance and implementation of this policy.

## **DEFINITIONS:**

**Covered Entity** means 1) health plan, 2) health care clearinghouse, or 3) healthcare provider that transmits information in electronic form.

## **POLICY:**

1. Morehouse Medical Associates (MMA) will provide patients with a written Notice of Privacy Practices as required by 45 Code of Federal Regulations (CFR) §164.520. This notice will inform patients of MMA's possible use and disclosure of protected health information, as well as the patient's rights, and covered entities legal duties with respect to disclosures of protected health information.
2. MMA will make every effort to accommodate patients who desire to exercise rights as spelled out in the Notice of Privacy Practices.
3. This policy is not applicable to inmates.
4. The Notice will be provided to patients with whom MMA has a direct treatment relationship.
5. The Notice will be provided to patients no later than the date of first service delivery, after the compliance date for the covered health care provider.
6. Upon request, the notice will be promptly provided to any patient.
7. The Notice of Privacy Practices will be provided to the patient by the Patient Service Representative promptly, at the MMA front desk.

8. The Notice of Privacy Practices will be posted in a clear and prominent location where it is reasonable to expect patients seeking services from the covered health care provider to be able to read the notice.
9. MMA will post its notice on the Morehouse School of Medicine (MSM) web site that provides information about its customer services or benefits, and will make the notice available electronically through the web site.
10. MMA will document compliance with and maintain the notice as applicable, by retaining copies of the notices issued for a period of at least six (6) years from the date of its creation or the date when it last was in effect, whichever is later.
11. Revised or changed Notice of Privacy Practices documents will be posted throughout the facility and relevant websites. The effective and revised date will be documented on the first page.
12. Knowledge of a violation or potential violation of this policy must be reported directly to the Compliance Office (404 756-1345) or to the ComplianceLine (1-888-756-1365).

**B. Procedures:**

1. Upon the first visit of the patient, on or after April 14, 2003, or when this policy and procedure is implemented (whichever is first), the Patient Service Representative will provide the patient with a copy of its most current Notice of Privacy Practices at the front registration desk.
2. An **Acknowledgement of Receipt of Notice of Privacy Practices** form will be presented to the patient for signature, to confirm receipt of the Notice of Privacy Practices. The patient will also be asked to indicate on this form, his or her preference for confidentially communicating protected health information.
3. MMA will request the patient to sign the Acknowledgment of Receipt of the Notice of Privacy Practices Form. If the patient refuses or is unable to sign, MMA will document the good faith effort to obtain acknowledgement of the same form.

**EXHIBIT (S)**

- I. Notice of Privacy Practices
- II. Acknowledgement of Receipt of Notice of Privacy Practices

By Direction of the Dean:

\_\_\_\_\_ Medical Director

## Exhibit I



### Notice of Privacy Practices

*Effective Date - April 14, 2003*

**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**

#### WHO WILL FOLLOW THIS NOTICE?

*This notice describes our practices and that of:*

- Any healthcare professional authorized to enter information into your medical record; and support staff authorized to handle your medical information.
- All departments and units of this organization.
- All employees, staff and faculty members of Morehouse Medical Associates, Morehouse Family Practice and affiliated clinics.
- All entities, sites and locations will follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for treatment, payment or hospital operations purposes, described in this notice.

#### OUR PLEDGE REGARDING MEDICAL INFORMATION:

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive from us. We need the record to provide you with quality care and to comply with certain legal requirements. This notice applies to all records of your care generated by us.

This notice describes how we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

*We are required by law to:*

- Protect the privacy of medical information that identifies you; and
- Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice that is currently in effect.

### **YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU**

- **Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records, but does not include psychotherapy notes.

To inspect and copy your medical information, submit a written request to the Supervisor of the Health Information Management Department. If you request a copy of the information, you will be charged a fee for the costs of copying, mailing and other supplies associated with your request.

- **Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, your request must be made in writing and submitted to the Health Information Management Supervisor. You must also provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition we may deny your request if you ask us to amend information that:
- Was not created by us;
  - Is not a part of the medical information kept by our facility;
  - Is not part of the information which you would be permitted to inspect or copy;
  - Is accurate and complete.

- **Right to an Accounting of Disclosures.** You have the right to request an “accounting of disclosures”. This is a list of disclosures we made of medical information about you to others, except for purposes of treatment, payment and operations. You must submit your request in writing to the Health Information Management Supervisor. Your request should state the time period, which may not be longer than 6 years and may not include dates before April 14, 2003. The first list within a 12-month period will be free. For additional lists, we may charge you for the costs involved.

- **Right to Request Restrictions.** You have the right to request restrictions or limitations on the medical information we use or disclose about you for treatment, payment or healthcare operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide necessary emergency care. To request restrictions, submit your request in writing to the Health Information Management Supervisor. The request must state a) what information you want to limit, b) whether you want to limit our use, disclosure or both and c) to whom you want the limits to apply.

- **Right to Request Confidential Communications.** You have a right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. Requests must be made to the Health Information Management Supervisor in writing. We will accommodate all reasonable requests. Your request must specify how and where you wish to be contacted.

- **Right to a Paper Copy of this Notice.** You have the right to a paper copy of this privacy notice. You may request a copy from any member of our staff at any time.

### **HOW MAY WE USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU?**

**Except for situations later discussed in this notice, we will use and disclose your medical information, only with your written authorization.** If you authorize us to use or disclose your medical information, you may revoke your authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose medical information about you for reasons covered in your written 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 we provided you.

*The following categories describe different ways that we may use and disclose medical information without your authorization.*

- **For Treatment.** We may use medical information about you to provide you with medical treatment and services. We may disclose your information to doctors, nurses, technicians, residents and medical students, clergy and others who are involved in your care. We may share medical information about you in order to coordinate the different things you need, for example, lab work or x-rays. We also disclose medical information about you to others in the community who may be involved in your medical care, such as long-term care facilities.
- **For Payment.** We may use or disclose medical information about you so that the treatment and services you receive may be billed to and payment may be collected from you, and insurance company or a third party. We may also tell your plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.
- **For Health Care Operations.** We may use and disclose your medical information for everyday operations. These uses and disclosures are necessary to run the facility and make sure that all of our patients receive quality care. We may disclose your information to doctors, nurses, technicians, residents and medical students, and other clinic personnel for review and learning purposes. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff. We may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when the physician is ready to see you.
- **Business Associates.** There are some services provided to our organization through contracts with business associates. Examples include physician services, radiology, and also certain laboratory services. When these services are contracted, we disclose your medical information to our business associates so that they can perform the job we asked them to do, and bill you or your third party payer for services rendered. To protect your health information, we require the business associates to appropriately safeguard your information.
- **Appointment Reminders.** We may use or disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at one of our facilities.
- **Treatment Alternatives.** We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.
- **Health-Related Benefits and Services.** We may use and disclose medical information to tell you about health-related benefits, services or medical education classes that may be of interest to you.
- **Individuals Involved in Your Care or Payment for Your Care.** We may release medical information about you to a caregiver who may be a friend or family member. We may also give information to someone who helps pay for your care.
- **Research.** Under certain circumstances, we may use and disclose your medical information for research purposes. All research projects are subject to approval by our Institutional Review Board. To participate in a given research project, we must obtain your authorization.
- **As Required by Law.** We will disclose medical information about you when required to do so by federal, state or local law.

***SPECIAL SITUATIONS.***

- **Military.** If you are a member of the armed forces, we may release medical information about you as required by military command authorities.
- **Worker's Compensation.** We may release your medical information for worker's compensation or similar legally established programs.
- **Public Health Risks.** We may disclose medical information about you for public health activities. We may use and disclose medical information about you to agencies when necessary to prevent serious threat to your health and the safety of the public or another person. These activities generally include the following:
  - To prevent or control disease, injury, disability;
  - To report births and deaths;
  - To report child abuse or neglect;
  - To report reactions to medications or product defects;
  - To enable product recalls;
  - To notify a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition; or
  - To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure when required by law.
- **Health Oversight Activities.** We may disclose your medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court order or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute.
- **Law Enforcement.** We may release medical information if asked to do so by a law enforcement official:
  - In response to a court order, subpoena, warrant, summons or similar process;
  - To identify or locate a suspect, fugitive, material witness, or missing person;
  - About a victim of crime, if, under certain limited circumstances, we are unable to obtain the person's agreement;
  - About death we may believe to be the result of criminal conduct;
  - About criminal conduct at the facility;
  - In emergency circumstances, to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

SUBJECT	HEALTH INFORMATION MANAGEMENT	POLICY #	0018
TITLE	PROVISION FOR NOTICE OF PRIVACY PRACTICES	EFFECTIVE DATE:	April 14, 2003

- **Coroners and Medical Examiners.** We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death.

#### **CHANGES TO THIS NOTICE.**

- We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice throughout the facility. The notice will contain on the first page, the effective date

#### **COMPLAINTS.**

If you believe that your privacy rights have been violated, you may contact or submit your complaint in writing to our **Compliance Office, 22 Piedmont Ave, Room 125, Atlanta, GA 30303.**

If we cannot resolve your concern, you also have the right to file a written complaint with the **Office of the Secretary of the Department of Health and Human Services, Region IV, Atlanta Federal Center, Forsyth Street, S.W., Suite 5B95, Atlanta, Georgia 30303-8909.**

**The quality of your care will not be jeopardized nor will you be penalized for filing a complaint**

#### **IF YOU HAVE QUESTIONS, CONTACT US.**

We welcome the opportunity to answer additional questions you may have about this notice. **You may call us at 404 756-1345 or write us at the Compliance Office, 22 Piedmont Avenue, Room 125, GA 30303. To write our Health Information Management Department, you may do so at: Morehouse Medical Associates, Health Information Management Department, Suite 700, 75 Piedmont Avenue, NE Atlanta, Georgia 30303.**

**Exhibit II**  
**Morehouse Medical Associates (MMA)**  
**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**  
**Effective Date - April 14, 2003**

**PATIENT'S NAME** \_\_\_\_\_ **MR #** \_\_\_\_\_

1. I understand that as part of my health care, MMA originates, records, and maintains health information about me, describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment, as well as claims and payment status. I understand that this health information may be used or disclosed by MMA for treatment, payment, and health care operations. For example, my health information serves as:
  - A basis for planning for my care and treatment;
  - A means of communication among the many health professionals who contribute to my care;
  - A source of information for applying my diagnoses and surgical information to my bill;
  - A means by which a third party payor can verify that services billed were actually provided; and
  - A tool for routine health care operations, such as assessing quality and reviewing the competence of health care professionals.
  
2. I acknowledge that I have been provided with MMA's Notice of Privacy Practices that provides a more complete description of information uses and disclosures and my rights regarding my medical information. I understand that MMA reserves the right to change its Notice of Privacy Practices and at my request, will make available to me, a copy of any revised notice.
  
3. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment payment or healthcare operations, and that MMA is not required to agree to the restrictions requested. If it does, it is bound by such restrictions.

***FOR CONFIDENTIAL COMMUNICATION:***

**CONTACT ME**       **by phone, or**    **by mail,  at home or  at work**

\_\_\_\_\_  
Print Name of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient (i.e. legal guardian, power of attorney)

Witness \_\_\_\_\_ Date \_\_\_\_\_

**For Office Use Only**

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**Morehouse Medical Associates, Inc. (MMA) has made a good-faith effort to obtain written acknowledgement of the Notice of Privacy Practices. However, written acknowledgement was not obtained due to reasons listed below.**

**WRITTEN ACKNOWLEDGMENT NOT OBTAINED**

- í Notice of Privacy Practices Given – Patient Unable to Sign
- í Notice of Privacy Practices Given – Patient Declined to Sign
- í Notice of Privacy Practices and Acknowledgement Mailed to Patient
- í Other Reason Patient Did Not Sign

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Signature of MMA Representative

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Date

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Printed Name of MMA Representative

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Department