

Kathleen Leavy RN, AP

NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

The privacy of your health information is important to us.

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect May 1, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. This may include your primary physician, their PA or nurse, physical therapist, nutritionist or dentist.

Healthcare Operations: We may use or disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualification of healthcare professionals, evaluation of practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect.

To Your Family and Persons Involved in your Care: We must disclose your health information to you. With your authorization, we may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare. We may use or disclose health information to notify, or assist in the notification to you. We will also use our professional judgment and our experience with common practice to

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make reasonable inferences of your best interest in allowing a person to pick up filled herbal prescriptions, medical supplies, or other similar forms of health information.

Required by law: We may use or disclose your health information when we are required to do so by law.

Public Health Activities: We may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public authorities.

Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.

Law Enforcement: Subject to certain restrictions, we may disclose information required by law enforcement officials.

Serious Threat to Health and Safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health and safety of others.

Appointment Reminders or Changes: We may use or disclose your health information to provide you with appointment reminders, make appointment changes, suggest treatment alternatives or return your phone calls. We will request written notice of how you would like all telephone contact to be made.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information. You must make a request in writing to obtain access to your health information. We will charge you a reasonable cost-based fee for expenses such as copies and staff time.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations. If you request this accounting more than once every 12 months period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these restrictions, but if we do, we will abide by our agreement (except in an emergency).

Amendment: You have the right to request that we amend your health information (Your request must be in writing, and it must explain why the information should be amended). We may deny your request under certain circumstances.

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QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information, you may complain to us. You may also submit a written complaint with the U.S. Department of Health and Human Service.

Privacy Officer: Kathleen Leavy RN, AP
Telephone: 352-379-6171
Address: 804 NW 16th Ave Suite A, Gainesville FL, 32601

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of
this office's Notice of Privacy Practices.

I would like to receive telephone communication or messages via:
(Check all that apply)

Home phone: _____

Work phone: _____

Cell phone: _____

Pager: _____

Please print name

Please sign name (signature)

Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our notice of Privacy Practices,
but the acknowledgement could not be obtained because:

Individual refused to sign

Communication barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised notice of Privacy Practices. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices at any time.

You will have the right to revoke this consent at any time by giving us written notice of your revocation. Please understand that revocation of this consent will not affect any action that we took in reliance on this consent before we received your revocation, and we may decline to treat you or to continue treating you if you revoke this consent.

I authorize you to disclose health information to (leave message with, pick-up herbs etc.):

No person at this time.

Spouse: _____

Family member: _____

Friend: _____

I, _____, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature: _____ Date: _____

Social Security Number: _____

REVOCAION OF CONSENT

I revoke my consent for your use and disclosure of my protected health information, payment activities, and healthcare operations.

I understand that revocation of my consent will not affect action you took in reliance on my consent before you received this written notice of revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my consent.

Signature: _____ Date: _____

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Authorization for Release of Protected Health Information

I, _____, authorize Kathleen Leavy RN, AP, to release my protected health information (medical record), to the following person or institution:

I understand that I will be charged a fee of at least \$25 or more based on the cost of responding to this request.

Signature: _____ Date: _____

For office use only

Date authorization received by office: _____ Initials: _____

Personally released to patient.

Mailed via certified mail to person and address requested (attach postal form to this authorization)

Personally delivered to person and address requested.

Date request completed: _____ Signature: _____

I acknowledge the receipt of medical records for _____, as authorized by this Release of Protected Health Information.

Signature: _____ Date: _____

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Privacy Practices Policy

Policy: It is the policy of Kathleen Leavy RN, AP to protect the health information of her patients as required by federal and state law.

Procedures:

USES AND DISCLOSURES OF HEALTH INFORMATION

Treatment: We may use or disclose health information to a physician or other healthcare Personnel providing treatment to our patients. This may include but is not limited to their primary physician, PA or nurse, physical therapist, nutritionist or dentist.

Healthcare Operations: We may use or disclose health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualification of healthcare professionals, evaluation of practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Patient Authorization: In addition to our use of health information for treatment, payment or healthcare operations, the patient may give us written authorization to release their health information or to disclose it to anyone for any purpose. If the patient gives us authorization, they may revoke it in writing at any time. Their revocation will not affect any use or disclosures permitted by their authorization while it was in effect.

Family and Persons Involved in their Care: We must disclose health information to the patient. With their authorization, we may disclose their health information to a family member, friend or other person to the extent necessary to help with their healthcare or with payment for their healthcare. We may use or disclose health information to communicate, notify, or assist in the notification to the patient. We will also use our professional judgment and our experience with common practice to make reasonable inferences of the patient's best interest in allowing a person to pick up filled herbal prescriptions, medical supplies, or other similar forms of health information.

Required by law: We may use or disclose health information when we are required to do so by

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law.

Public Health Activities: We may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public authorities.

Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.

Law Enforcement: Subject to certain restrictions, we may disclose information required by law enforcement officials.

Serious Threat to Health and Safety: We may use and disclose information when necessary to prevent a serious threat to the patient's health and safety or the health and safety of the public or another person.

Workers Compensation: We may release information about the patient for workers compensation or similar programs providing benefits for work-related injuries or illness.

Abuse or Neglect: We may disclose health information to appropriate authorities if we reasonably believe that the patient is possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose health information to the extent necessary to avert a serious threat to the patient's health or safety or the health and safety of others.

Appointment Reminders or Changes: We may use or disclose health information to provide the patient with appointment reminders, make appointment changes, suggest treatment alternatives or return patient phone calls. We will request written notice of how the patient would like all telephone contact to be made.

PATIENT RIGHTS

Access: Patients have the right to look at or get copies of their health information. The patient must make a request in writing to obtain access to their health information. We will charge the patient at least \$25 or a reasonable cost-based fee for expenses such as copies and staff time.

Disclosure Accounting: Patients have the right to receive a list of instances in which we or our business associates disclosed their health information for purposes, other than treatment, payment, healthcare operations. If the patient requests this accounting more than once every 12 month period, we may charge them a reasonable, cost-based fee for responding to these additional requests.

Restrictions: Patients have the right to request that we place additional restrictions on our use or disclosure of their health information. We are not required to agree to these restrictions, but if we do, we will abide by our agreement (except in an emergency).

Amendment: Patients have the right to request that we amend their health information their request must be in writing, and it must explain why the information should be amended. We may deny their request under certain circumstances.

Revocation of consent: Patients have the right to revoke their consent at any time. They must give written notice of their revocation of consent. This revocation will not affect any action taken in reliance on this consent prior to receiving the written revocation of consent. We have the right to decline to treat the patient or to continue to treat the patient, if they revoke this consent.

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COMPLAINTS

Patients have the right to complain if they feel that Kathleen Leavy RN, AP, may have violated their privacy rights or if they disagree with a decision she made about access to their health information or our response to a request made to amend or restrict the use or disclosure of their health information.

They also have the right to submit a written complaint to:

U.S. Department of Health and Human Services
Attention: Office of Civil Rights
Sam Nunn Atlanta Federal Center, Suite 3B70
61 Forsyth Street SW
Atlanta, GA 32303-8909

Attachment: Public Law 104-191 Health Insurance Portability and Accountability Act of 1996