

FAIRFAX COLON & RECTAL SURGERY, P.C.

DONALD B. COLVIN, M.D., F.A.S.C.R.S.

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COLORECTAL/ANORECTAL SURGERY, COLONOSCOPY, ANORECTAL PHYSIOLOGY

PRIVACY NOTICE

The Department of Health and Human Services, Office of Civil Rights, under the Public Law 104-191, (*The Health Insurance Portability and Accountability Act of 1996*) (*HIPAA*), mandates that we issue this new revised Privacy Notice to our patients. This notice to our patients meets all current requirements as it relates to *Standards for Privacy of Individually Identifiable Information (IIHI)*; affecting our patients. You are urged to read this notice.

As part of the Privacy Standard, implemented on April 14, 2001, you are required to provide this office with a new signed and dated, *Privacy Notice*. Every patient must receive our new Privacy Notice, and may be required to execute a new Consent Agreement, defining how this office may use your information for treatment, payment, or other health care operations (TPO).

Our Privacy Notice informs you of our use and disclosure of your *Protected Health Information (PHI)*, defined as: “any information, whether oral or recorded in any medium, that is either created or received by a health care provider, health plan, public health authority, employer, life insurance company, school or university or clearinghouse and that relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past present or future payment for the provision of health care to an individual”.

Our office will use or disclose your PHI for purposes of treatment, payment and other healthcare purposes as required to provide you the best quality healthcare services that we offer to the extent permitted by your Consent Agreement or in such specific situations, by your signed and dated Authorization. It is our policy to control access to your PHI; and even in cases where access is permitted, we exercise a “minimum necessary information” restriction to that access. We define the minimum necessary information as the minimum necessary to accomplish the intent of the request.

An Authorization differs from a Consent Agreement in that it is very specific with regard to the information allowed to be disclosed or used, the individual or entity to which the information may be disclosed to, the intent for which it may be disclosed, and the date that it was initiated which may include the duration of the authorization. This is a form, separate from the Consent Agreement, and usually used only for one specific request for information. In the event of a non-healthcare related request for personal health information this office will request you to complete an Authorization Form.

You, as our patient, may revoke any Consent or Authorization at any time and all use and disclosure and administration of related healthcare services will be revised accordingly, with the exception of matters already in process as a result of prior use of your PHI. To revoke either the Consent Agreement or the Authorization you will have to provide this office with a written request with your signature and date and your specific instructions regarding an existing Authorization or Consent Agreement. Any revocation will not apply to information already used or disclosed.

If you had a “personal representative” initiate an Authorization you may revoke that authorization at any time.

You, the patient, have access to your health care information and may request to examine your information, may request copies of your information, and under the law you may request amendments to your information. The physician or principal will exercise professional judgment with regard to requests for amendments and is not bound by law to make any changes to the information. If the physician or professional agrees with the request to amend the information, we are bound by law to abide by the changes.

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In limited circumstance, The Privacy Standard permits, but does not require, covered entities to continue certain existing disclosures of health information without individual authorization for specific public responsibilities.

These permitted disclosures include, emergency circumstances; identification of the body of a deceased person, or to assist in determining the cause of death; public health needs; research, generally limited to when a waiver of authorization is independently approved by a privacy board or Institutional Review Board; oversight of the health care system; judicial and administrative proceedings; limited law enforcement activities; and activities related to national defense and security. There are specific state laws that require the disclosure of health care information related to Hepatitis C, and AIDS. Where the state laws are more stringent than HIPAA Privacy Standard, the state laws will prevail.

All of these disclosures could occur previously under former laws and regulations however; The Privacy Standard establishes new safeguards and limits. If there is no other law requiring that your information be disclosed, we will use our professional judgments to decide whether to disclose any information, reflecting our own policies and ethical principals.

On some occasions we may furnish your PHI to a third party. This could be an insurance company for the purpose of payment or another health care provider for further treatment or additional services. Although will institute a "chain of trust" contract and monitor our business associates' contracts with us, we cannot absolutely guarantee that they will not use or disclose your PHI in such a way as to violate the Privacy Standard.

Although the law requires a signed and dated Privacy Notice, this office does not demand that you sign the agreements as a condition of receiving care. It is the law that your rights are communicated in this manner.

It is our practice to retain information about non-healthcare related requests for your health care information for a period of six years.

In complying with the Privacy Standard, we have appointed a Privacy Officer, trained our Privacy Officer and the staff in the law, and implemented policies to protect your PHI. We have instituted privacy and security processes to guard and protect your PHI. This office is taking and continues to monitor and improve steps for the protection of your information and to remain in compliance with the law.

Please sign below and date the form indicating that you have received the Privacy Notice.

Thank you.

Signature of patient or Personal Representative

Date: _____

Name printed

I, _____, understand that if in the event my account becomes past due(over 30 days) and all attempts to arrange payment have failed, it will be turned over to an attorney for collection. I also understand that I will be responsible for all attorney's fees (33.3% of total past due amount) and all other costs expended to collect said amount.

I have read and understand the foregoing.

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_____ **Date:** _____