

**THE HAND CENTER OF WESTERN MASSACHUSETTS
NOTICE OF PRIVACY PRACTICES
Effective 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.

It is very important to The Hand Center of Western Massachusetts to protect your personal health information (PHI). We want you to have a clear understanding of how we use and safeguard your protected health information.*

We create a record of care and services you receive at our office or at the recommendation of our office. We need this record to provide you with quality care, and to comply with certain legal requirements. These Standards for Privacy of Individually Identifiable Health Information (the "Privacy Regulation") are published by the U.S. Department of Health and Human Services ("HHS") at 45 C.F.R. parts 160 and 164 under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). They are interpreted and amended from time to time, for so long as such regulations are in effect.

This notice of privacy practices will describe your rights and certain duties we have regarding the use and disclosure of medical information. It also describes how we may use your PHI* in order to carry out treatment, payment, and health care operations. This notice also contains your right to access and control your PHI*.

We are required to abide by the terms of this notice. However, we may modify the terms of this notice at any time, and the new notice will be effective for all PHI* in our possession at the time of the change, and any received thereafter. Upon request, we will provide you with any revised notice or you can review the notice by accessing our website at <http://www.handctr.com>.

Uses and Disclosures of Health Information:

We use PHI* about you for treatment, payment, and health care operation purposes. We do not require authorization to use your PHI* for these purposes. We may also use or disclose your PHI* without your authorization for several other reasons. Subject to certain requirements, we may give out health information without your authorization for public health reasons, for auditing purposes, for research studies, and for emergencies.

Treatment: We may use PHI* about you to provide you with medical treatment or services. We may disclose PHI* about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share PHI* about you to your other health care providers to assist them in treating you.

Payment: We may use and disclose your PHI* for payment purposes.

Health Care Operations: We may use and disclose your PHI* for our health care operations. This may include measuring and improving quality, evaluating the performance of employees, conducting training programs, in getting certificates, accreditations, licenses and credentials we need to serve you.

Additional Uses and Disclosures: In addition to using and disclosing your PHI* for treatment, payment, and health care operations, we may use and disclose PHI* for the following purposes.

Appointment reminders: We have the right to use and disclose your PHI* to contact you and remind you of appointments.

Notification: We have the right to use and disclose PHI* to notify or help notify: a family member, your personal representative, or another person responsible for your care. We will share information about your

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location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse the permission.

We may also disclose PHI* by facsimile, email or via cell phone.

In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up prescriptions, medical supplies, x-rays, office notes, or any other medical information for you.

Research in Limited Circumstances: We may provide PHI* for research purposes in limited circumstances when the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of the medical information.

Health Related Benefits and Services: We may use and disclose PHI* to inform you of health related benefits or services that may be of interest to you.

Disclosures Required by Law: We will use and disclose your PHI* when we are required to do so by federal, state, or local law.

Court Orders and Judicial and Administrative Proceedings: We may disclose PHI* in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your PHI* with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim, or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or a correctional institution under certain circumstances.

Public Health Risks: As required by law, we may disclose your PHI* to public health authorities that are authorized by law to collect information for the purposes of:

- maintaining vital records, such as births and deaths;
- reporting child abuse or neglect;
- preventing or controlling disease, injury, or disability;
- notifying a person regarding potential exposure to a communicable disease;
- notifying a person regarding the potential risk for spreading or contracting a disease or condition;
- reporting reactions to drugs or problems with products or devices;
- notifying individuals of when a product or device they may be using has been recalled;
- notifying the appropriate government agencies and authorities regarding the potential abuse or neglect of an adult patient (including domestic violence); and
- notifying your employer under limited circumstances related primarily to work place injury or illness or medical surveillance.

Health Oversight: We may disclose your PHI* to a health oversight agency for activities authorized by law, including audits, civil, administrative or criminal investigations or proceedings; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health system in general.

Law Enforcement: We may disclose PHI* if asked by to do so by a law enforcement official;

- regarding a crime victim in certain situations;
- concerning a death we believe might have resulted from a criminal conduct;
- regarding criminal conduct at our office;
- to identify and/or locate a suspect, material witness, fugitive or missing person;
- in an emergency to report a crime (such as certain types of wounds).

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Serious Threats to Health or Safety: We may disclose PHI* when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a personal organization able to help prevent that threat.

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Military: We may disclose your PHI* if you are a member of the United States or foreign military forces and if required by the appropriate military command authorities.

National Security: We may disclose your PHI* to federal officials for intelligence and national security activities authorized by the law. We may also disclose to federal officials in order to protect the president, other officials, or foreign heads of state, or to conduct investigations.

Inmates: We may disclose your PHI* to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosures for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

Workers' Compensation: We may disclose your PHI* for workers' compensation and similar programs.

Your Rights:

The Right to Inspect and Copy: You have the right to inspect (while supervised by an employee of The Hand Center of Western Massachusetts) and obtain a copy of your PHI* that we maintain and have in our possession, including medical records and billing records, but not including psychotherapy notes. If you request copies, we will charge you a fee for the cost of copying, mailing, labor and supplies associated with your request. To inspect and copy your PHI*, you must submit your request in writing. Original records will not be permitted to leave the premises.

Under certain circumstances, we may deny your request to inspect and copy your PHI*. If you are denied access to medical information, you have the right to have that determination reviewed. A licensed health care professional will review your request and denial. The person conducting the review will not be the person who denied your request. The Hand Center of Western Massachusetts promises to comply with the outcome of the review.

The Right to Amend Your PHI*: If you feel that any PHI* we have about you is not correct or is incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is our work product and is kept by The Hand Center of Western Massachusetts. To request an amendment, your request must be made in writing. Additionally, you must provide a reason that supports your request.

The Hand Center of Western Massachusetts reserves the right to 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 The Hand Center of Western Massachusetts;
- is not part of the medical information kept by The Hand Center of Western Massachusetts;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

The Right to an Accounting of Disclosures: An accounting of disclosures is a list of the disclosures we have made, if any, of your PHI*.

You have the right to request an accounting of disclosures. The right applies to disclosures for purposes other

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than those made to carry out treatment, payment, and health care operations as described in this notice. It excludes disclosures made to you, or those made for notification purposes.

Your request must be made in writing and state a time period that cannot be longer than seven years and cannot include any dates before April 14, 2003. We may charge you for the cost of providing this list. We will notify you of the cost involved and you may choose to withdraw or modify your request at any time before any costs are incurred.

The Right to Receive Communications of PHI* by Alternative Means or at Alternative Locations: You have the right to request that The Hand Center of Western Massachusetts communicate with you about your health related issues in a particular manner or at a certain location. We will accommodate all reasonable requests made in writing. Your request to receive PHI* by an alternative means or at an alternative location must clearly state that your life could be endangered by the disclosure of all or part of your PHI*.

The Right to Request Restrictions: You have the right to request a restriction or limitation on the PHI* we use or disclose about you for treatment, payment or health care operations as described in this notice. 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 of your care (like a family member or friend), or for notification purposes as described in this notice.

Any request for a restriction on our use and disclosure of your PHI* must be made in writing. Your request must describe in a clear and concise manner: (a) the information you wish to be restricted; (b) whether you are requesting to limit The Hand Center of Western Massachusetts use, disclosure, or both; and (c) to whom you want the limits to apply. Please note that certain restrictions may affect our ability to communicate on your behalf to your insurance and would therefore leave you responsible for such payments.

The Right to Provide an Authorization for Other Uses and Disclosures: The Hand Center of Western Massachusetts will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI* may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI* for the purposes described in this authorization, except under the following circumstances:

- we have taken action in reliance upon your authorization before we received your written revocation;
- you were required to give us your authorization as a condition of obtaining coverage; or
- if state law gives us the right to contest a claim under your policy.

The Right to Obtain a Paper Copy of this Notice:

Upon request, you have the right to a paper copy of this notice, even if you have agreed to accept this notice electronically.

How to Contact Us:

If you have any complaints or questions about this notice or you want to submit a written request to The Hand Center of Western Massachusetts as required in any of the previous sections of this notice, please call (413) 733-2204 or write to us at the address below (there will be a standard form to be filled out):

Attention: The Hand Center of Western Massachusetts Privacy Officer

Address: The Hand Center of Western Massachusetts
3550 Main St. Suite #204
Springfield, MA 01107

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**THE HAND CENTER
OF WESTERN MASSACHUSETTS**

3550 Main Street, Suite 204

Springfield, MA 01107

(413) 733-2204

Fax (413) 734-0587

**THE HAND CENTER OF WESTERN MASSACHUSETTS
PRIVACY PRACTICES ACKNOWLEDGEMENT**

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient Name: _____ Patient DOB: _____
*If patient is a minor, a parent or guardian must sign.

Patient Signature: _____ Chart #: _____
*Patient, parent or guardian

Date: _____