

WOMEN'S HEALTH NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

Effective date: April 14, 2003 Updated: January 10, 2020

I. UNDERSTANDING YOUR HEALTH INFORMATION

Each time you visit Boulder Valley Women's Health Center an electronic record of your visit is created. This record contains your name and other information about you, including your symptoms, examination and test results, diagnoses, treatment, plan for future health care, and financial information. This record is sometimes referred to as your "medical record" or "medical chart." This record allows:

- Doctors, nurses, and other health professionals to plan your treatment;
- Boulder Valley Women's Health Center to obtain payment for services we provide to you, such as from health plans, Medicare/Medicaid, or you; and
- Our medical practice to measure the quality of care provided to you.

As in the past, we are committed to keeping your health information confidential. We will not use or give to others your health information without your written permission, except as stated in this Notice.

II. HOW WE WILL USE AND SHARE YOUR HEALTH INFORMATION

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS: In accordance with the law, we will use and give out your health information to provide you with health care **treatments**, to get paid for our services, and to help us operate our medical practice. For example:

- We may give your health information to health care professionals not on our staff, such as other doctors and hospital staff, who help care for you. This health information may be shared via fax, paper or electronic formats. Your provider is a member of a community of practices (Integrated Physician Network) that use a common enterprise medical record to make your healthcare safer, more efficient and of highest quality. Your health information may be shared electronically within this network with other physicians, providers and practices but only if they are participating in your care.
- We may send a bill to your health insurance plan or to you.
- Our medical practice may use your medical record to review the performance of your healthcare team and to assist them in their mission to deliver quality, safe and efficient health care.

OTHER USES AND DISCLOSURES ALLOWED OR REQUIRED BY FEDERAL LAW: We may use or share your health information for the following purposes under limited circumstances:

- To people designated by you and who are involved in your care or who help pay for your care (such as your family, your close friends, or any other person you chose) to notify them of your location, general health, and to assist you in your health care (such as to pick-up medicine or help with follow-up care).
- To government agencies that oversee our medical practice or community health centers (such as provider license and certification inspectors) as required by law.
- To government agencies that have the right to receive and collect health information (such as public health officials).
- When we are ordered by a court or judge.
- To workers' compensation programs when your health problem is from a work-related injury.
- When law enforcement requests information in conjunction with a criminal investigation (such as to prevent danger or injury).
- To coroners and/or funeral directors to allow them to carry out their duties.
- To organ donor agencies (subject to applicable laws).
- To avoid a serious threat to the health or safety of others.
- We may share limited health information to business associates of Boulder Valley Women's Health Center only to the extent this information is essential to help us perform required tasks, such as

working with our accountants, computer consultants, and billing companies (and ONLY if the business associate agrees in writing to keep your health information confidential as required by law).

- For any other purpose required or allowed by law and as required for HIPAA-compliant participation in the Colorado Regional Health Information Exchange.

OTHER USES AND DISCLOSURES REQUIRING YOUR WRITTEN PERMISSION: Except as stated above, we will only use or give out your health information after getting your WRITTEN permission on a Records Release Authorization form. You may revoke your authorization(s) at any time by notifying us in writing that you wish to do so.

III. YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION:

Subject to certain legal limits, you have rights regarding the use and disclosure of your health information. These rights include:

- Requesting limits on uses of your health information.
- Receiving confidential communications of your health information.
- Inspecting and copying your health information for your own use.
- Requesting a change to your health information.
- Receiving a record of how we have used and shared your health information.
- Obtaining a copy of this Notice of Privacy Practices.

Patients will be notified if their protected health information is subject to a breach of confidentiality. Although our practice has no intention of contacting you to raise funds at any time in the future, we are required by law to state that an individual has a right to opt out of receiving such communications if received.

IV. QUESTIONS, CONCERNS, AND CHANGES TO THIS NOTICE

If you have any questions or concerns about any of the information in this Notice of Privacy Practices, please contact our Clinic HIPAA Officer.

If you believe your privacy rights have been violated, you may file a complaint with our Clinic HIPAA Officer (303) 442-5160, or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. We will not retaliate against you for filing a complaint.

We may change our Notice of Privacy Practices in the future. Such changes will apply to your health information that we created or received before the effective date of the change. We will notify you of any changes to our Notice of Privacy Practices by distributing the changed Notice during future office visits and by posting it in our reception areas.

ACKNOWLEDGMENT OF RECEIPT OF THE “NOTICE OF PRIVACY PRACTICES” MUST BE MADE IN WRITING AND A COPY KEPT IN YOUR MEDICAL RECORD. PLEASE SIGN AND RETURN THE ATTACHED SIGNATURE PAGE.

I hereby acknowledge receipt of Women’s Health NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES. I have signed below stating that I have been given an opportunity to read the NOTICE and to ask questions.

Name: _____ **Date of Birth:** ____/____/_____

Signature: _____ **Date:** ____/____/_____