

**7 HOLLAND WAY, EXETER, NH 03833**

## **Notice of Privacy Practices**

**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.**

### **I. Our Privacy Obligations**

We are required by law to maintain the privacy of medical and health information about you (“Protected Health Information” or “PHI”) and to provide you with this Notice of our legal duties and privacy practices with respect to PHI. When we use or disclose PHI, we are required to abide by the terms of this Notice (or other notice in effect at the time of the use or disclosure).

### **II. Permissible Uses and Disclosures Without Your Written Authorization**

In certain situations, which we will describe in Section IV below, we must obtain your written authorization in order to use and/or disclose your PHI. However, we do not need any type of authorization from you for the following uses and disclosures:

**A. Use and Disclosure With For Treatment, Payment and Health Care Operations.** We may use and disclose PHI, but not your “Highly Confidential Information” (defined in Section III. C below), in order to treat you, obtain payment for services provided to you and conduct our “health care operations” (e.g., internal administration, quality improvement and customer service) as detailed below:

**Treatment.** We use and disclose PHI to provide treatment and other services to you--for example, to diagnose and treat your injury or illness. In addition, we, or one of our Business Associates, may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also disclose PHI to other providers involved in your treatment.

**Payment.** We may use and disclose PHI to obtain payment for services that we provide to you--for example, disclosures to claim and obtain payment from your health insurer, HMO, or other company that arranges or pays the cost of some or all of your health care (“Your Payor”), or to verify that Your Payor will pay for health care.

**Health Care Operations.** We may use and disclose PHI for our health care operations, which include internal administration and planning and various activities that improve the quality and cost effectiveness of the care that we deliver to you. For example, we may use PHI to evaluate the quality and competence of our physicians, nurses and other health care workers. We may disclose PHI to our office manager in order to resolve any complaints you may have and ensure that you have a pleasant visit with us.

We may also disclose PHI to your other health care providers when such PHI is required for them to treat you, receive payment for services they render to you, or conduct certain health care operations, such as quality assessment and improvement activities, reviewing the quality and competence of health care professionals, or for health care fraud and abuse detection or compliance.

**Business Associates.** We may sometimes disclose PHI to organizations or individuals that assist us in performing some Health Care Operations. Our agreements with these “Business Associates” provide for continued privacy protection of that protected health information.

**B. Disclosure to Relatives, Close Friends and Other Caregivers.** We may use or disclose PHI to a family member, other relative, a close personal friend or any other person identified by you when you are present for, or otherwise available prior to, the disclosure. If you object to such uses or disclosures, please notify the Practice Manager or Physician.

If you are not present, you are incapacitated, or in an emergency circumstance, we may exercise our professional judgment to determine whether a disclosure is in your best interests. If we disclose information to a family member, other relative or a close personal friend, we would disclose only information that is directly relevant to the person’s involvement with your health care or payment related to your health care. We may also disclose PHI in order to notify (or assist in notifying) such persons of your location, general condition or death.

**C. Public Health Activities.** We may disclose PHI for the following public health activities: (1) to report health information to public health authorities for the purpose of preventing or controlling disease, injury or disability; (2) to report child abuse and neglect to public health authorities or other government authorities authorized by law to receive such reports; (3) to report information about products and services under the jurisdiction of the U.S. Food and Drug Administration; (4) to alert 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; and (5) to report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.

**D. Victims of Abuse, Neglect or Domestic Violence.** If we reasonably believe you are a victim of abuse, neglect or domestic violence, we may disclose PHI to a governmental authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence.

**E. Health Oversight Activities.** We may disclose PHI to a health oversight agency that oversees the health care system and is charged with responsibility for ensuring compliance with the rules of government health programs such as Medicare or Medicaid.

**F. Judicial and Administrative Proceedings.** We may disclose PHI in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.

**G. Law Enforcement Officials.** We may disclose PHI to the police or other law enforcement officials as required or permitted by law or in compliance with a court order or a grand jury or administrative subpoena.

**H. Decedents.** We may disclose PHI to a coroner or medical examiner as authorized by law.

**I. Organ and Tissue Procurement.** We may disclose PHI to organizations that facilitate organ, eye or tissue procurement, banking or transplantation.

**J. Research.** We may use or disclose PHI without your consent or authorization if an Institutional Review Board/Privacy Board approves a waiver of authorization for disclosure.

**K. Health or Safety.** We may use or disclose PHI to prevent or lessen a serious and imminent threat to a person’s or the public’s health or safety.

**L. Specialized Government Functions.** We may use and disclose PHI to units of the government with special functions, such as the U.S. military or the U.S. Department of State under certain circumstances required by law.

**M. Workers' Compensation.** We may disclose PHI as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs.

**N. As required by law.** We may use and disclose PHI when required to do so by any other law not already referred to in the preceding categories.

### **III. Use and Disclosures Requiring Your Written Authorization**

**A. Use or Disclosure with Your Authorization.** For any purpose other than the ones described in Section III, we only may use or disclose PHI when (1) you give us your authorization on our authorization form ("Your Authorization"). For instance, you will need to execute an authorization form before we can send PHI to your life insurance company, to your child's camp or school, or to the attorney representing the other party in litigation in which you are involved.

**B. Marketing Communications.** We must also obtain your written authorization ("Your Marketing Authorization") prior to using PHI to send you any marketing materials. (We can, however, provide you with marketing materials in a face-to-face encounter, without obtaining Your Marketing Authorization. We are also permitted to give you a promotional gift of nominal value, if we so choose, without obtaining Your Marketing Authorization.) In addition, we may communicate with you about products or services relating to your treatment, case management or care coordination, or alternative treatments, therapies, providers or care settings. We may use or disclose PHI to identify health-related services and products that may be beneficial to your health and then contact you about the services and products.

**C. Uses and Disclosures of Your Highly Confidential Information.** In addition, federal and state law requires special privacy protections for certain highly confidential information about you ("Highly Confidential Information"), including the subset of your PHI that: (1) is maintained in psychotherapy notes; (2) is about mental health and developmental disabilities services; (3) is about alcohol and drug abuse prevention, treatment and referral; (4) is about HIV/AIDS testing, diagnosis or treatment; (5) is about venereal disease(s); (6) is about genetic testing; (7) is about child abuse and neglect; (8) is about domestic abuse of an adult with a disability; or (9) is about sexual assault. In order for us to disclose your Highly Confidential Information for a purpose other than those permitted by law, we must obtain your written authorization.

### **IV. Your Individual Rights**

**A. For Further Information; Complaints.** If you desire further information about your privacy rights, are concerned that we have violated your privacy rights or disagree with a decision that we made about access to PHI, you may contact our Practice Manager. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services, 200 Independence Avenue, SW, - Room 506-F, Washington, DC 20201 (Tel: 202-619-0403). Upon request, Core's Privacy Officer will provide you with the correct address for the Director. We will not discriminate against you if you file a complaint with us or the Director.

**B. Right to Request Additional Restrictions.** You may request restrictions on our use and disclosure of PHI (1) for treatment, payment and health care operations, (2) to individuals (such as a family member, other relative, close personal friend or any other person identified by you) involved with your care or with payment related to your care, or (3) to notify or assist in the notification of such individuals regarding your location and general condition. All requests for such restrictions must be made in writing. While we will consider all requests for additional restrictions carefully, we are not required to agree to a requested restriction. If you wish to request additional restrictions, please obtain a request form from our

Practice Manager and submit the completed form to the Practice Manager. We will send you a written response.

**C. Right to Receive Confidential Communications.** You may request, and we will accommodate, any reasonable written request for you to receive PHI by alternative means of communication or at alternative locations.

**D. Right to Inspect and Copy Your Health Information.** You may request access to your medical record file and billing records maintained by us in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, we may deny you access to your records. If you desire access to your records, please obtain a record request form from our office and submit the completed form. If you request copies The practice may charge \$15 for the first 30 pages or \$.50 per page, whichever is greater, for copying fees as well as any applicable mailing fess necessary to complete the request. The State of New Hampshire, Senate Bill 42, allows such fees.

**E. Right to Revoke Your Authorization.** You may revoke Your Authorization, Your Marketing Authorization or any written authorization obtained in connection with your Highly Confidential Information, except to the extent that we have taken action in reliance upon it, by delivering a written revocation statement to the Practice Manager..

**F. Right to Amend Your Records.** You have the right to request that we amend PHI maintained in your medical record file or billing records. If you desire to amend your records, please obtain an amendment request form from the Practice Manager and submit the completed form to the Practice Manager. All requests for amendments must be in writing. We will comply with your request unless we believe that the information that would be amended is accurate and complete or other special circumstances apply.

**G. Right to Receive An Accounting of Disclosures.** Upon written request, you may obtain an accounting of certain disclosures of PHI made by us during any period of time prior to the date of your request provided such period does not exceed six years and does not apply to disclosures that occurred prior to April 14, 2003. If you request an accounting more than once during a twelve (12) month period, the practice may charge \$15 for the first 30 pages or \$.50 per page, whichever is greater for copying fees as well as any applicable mailing fees necessary to complete the request. The State of New Hampshire, Senate Bill 42, allows such fees.

**H. Right to Receive Paper Copy of this Notice.** Upon written request, you may obtain a paper copy of this Notice, even if you agreed to receive such notice electronically.

**V. Effective Date and Duration of This Notice**

**A. Effective Date.** This Notice is effective on April 14, 2003.

**B. Right to Change Terms of this Notice.** We may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all PHI that we maintain, including any information created or received prior to issuing the new notice. If we change this Notice, we will post the revised notice in waiting areas of the Practice and on our Internet site at [www.CorePhysicians.org](http://www.CorePhysicians.org). You may also obtain any revised notice by contacting the Practice Manager.

**VI. Privacy Officer**

You may contact the Privacy Officer at:

Core Physicians  
Attn: Privacy Officer  
7 Holland Way  
Exeter, NH 03833

**Acknowledgement of Receipt of Privacy Practices:**

I, the undersigned, understand that Core Physicians is required by law to maintain the privacy of protected health information and provide me a notice of their legal duties and privacy practices regarding health information about me. My signature below attests that I have read, understood, and agree with the Notice of Privacy Practices that describe how medical information about me may be used and disclosed and how I can have access to this information.

\_\_\_\_\_  
Signature of Patient or Patient's Personal Representative

\_\_\_\_\_  
Personal Representative Authority

\_\_\_\_\_  
Printed Name of Patient or Patients Personal Representative

\_\_\_\_\_  
Date