



## Notice of Privacy Practices

This notice describes how your medical information may be used and disclosed and how you can get access to this information. Please read carefully.

Definitions – You may see or hear terms in relation to this Notice. Some of the terms you may hear, and their definitions are:

1. **Protected Health Information or PHI:** Your personal and protected health information that we use to render care to you and bill for services provided.
2. **Privacy Officer:** The individual in the clinic who has the responsibility for developing and implementing all policies and procedures concerning your **PHI** and receiving and investigating any complaints you may have about the use and disclosure of your **PHI**.
3. **Business Associate:** An individual or business independent of the clinic that works for the clinic to help provide the clinic and/or you with services.
4. **Authorization:** We will obtain authorization from you, giving us permission to use or disclose your **PHI** for purposes other than for your treatment, to obtain payment of your bills, and for health care operations of this clinic.

Fairfax Medical Facilities, Inc. creates records of the care and services you receive. Your medical records and billing information are systematically created and retained on a variety of media which may include computers, paper, and films. This information is accessible to clinic personnel and members of the medical staff. Proper safeguards are in place to discourage improper use or access. We are required by law to protect your privacy and the confidentiality of your personal and protected health information and records. This notice describes your rights and our legal duties regarding your **PHI**. The entities covered by this notice include this clinic, and all health care providers who are members of our medical, dental, and ancillary staff.

Fairfax Medical Facilities, Inc. may use and disclose your **PHI** without your authorization for the following:

1. **Treatment:** We may use **PHI** about you to doctors, nurses, technicians, medical students, or other clinic personnel who are involved with your care at the clinic. For example, a doctor treating you for a broken leg may need to know if you are a diabetic, because diabetes slows the healing process. ‘
2. **Payment:** We may use **PHI** about you so that the treatment and services you receive at the clinic may be billed to and payment be collected from you, insurance companies, or third parties. For example, we may need to give your health plan information about lab work received at the clinic so your health plan will pay us for these services.
3. **Health Care Operations:** We may use and disclose **PHI** about you for clinic operations. These uses and disclosures are necessary to run the clinic and make sure our patients receive quality care. For example, we may use **PHI** about your high blood pressure to review our treatment and services, to evaluate the performance of our staff caring for you, and to train health professionals.



4. **Business Associates:** We may disclose your **PHI** to Business Associates independent of the clinic with whom we contract to provide services on our behalf. However, we will only make these disclosures if we have received satisfactory assurance that the Business Associate will properly safeguard your privacy and the confidentiality of your **PHI**. For example, we may contract with a company outside of the clinic to provide collection services for past due amounts.
5. **Appointment Reminders:** We may use and disclose your **PHI** to contact you as a reminder that you have a medical, dental, or behavioral appointment at the clinic. This may be done through an automated system or by one of our staff members. If you are not at home, we may leave this information on your answering machine or in a message left with the person answering the phone.
6. **Health Related Benefits and Services:** We may use and disclose your **PHI** to tell you about health-related benefits or services or recommend possible treatment options or alternatives that may be of interest to you.
7. **Clinic Registration:** We may disclose certain limited information about you from the registration desk at the time of your appointment. This information may include your name, location in the clinic and your general condition. This information will only be released to people who ask for you by name.
8. **Individuals Involved in Your Care or Payment for Your Care:** We may release **PHI** to a friend or family member who is involved in your medical care. We may also give **PHI** to someone who helps pay for your care. We may also disclose **PHI** about you to an entity assisting in disaster relief so that your family may be notified about your condition, status, and location.
9. **Research:** Under certain circumstances, we may use and disclose **PHI** about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received a different medication for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of **PHI**, trying to blanket the research needs with the patients' need for privacy of their **PHI**. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose **PHI** about people preparing to conduct a research project. For example, to help them look for patients with specific medical needs, so long as the **PHI** they review does not leave the clinic. We will almost always ask for your specific permission if the researcher will have access to your name, address, or other information that reveals who you are, or will be involved in your care at the clinic.
10. **As Required by Law:** We will disclose **PHI** about you when required to do so by federal, state, or local law. For example, Oklahoma law requires us to report all births and deaths that occur in the clinic to the Oklahoma Department of Health.
11. **To Avert a Serious Health Threat or Injury:** We may use and disclose **PHI** about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.
12. **Organs and Tissues Donations:** If you are an organ donor, we may release **PHI** to organizations that handle organ procurement or organ, eye, or tissue transplantation, or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.



13. **Military:** If you are member of the armed forces, we may release **PHI** about you as required by military command authorities. We may also release **PHI** about foreign military personnel to the appropriate foreign military authority.
14. **Workers' Compensation:** We may release **PHI** about you for worker's compensation or similar programs as authorized by state law. These programs provide benefits for work-related injuries or illnesses.
15. **Public Health Reporting:** We may disclose **PHI** about you for public health activities. For example:
  - a. Prevent or control disease, injury, or disability
  - b. Report birth defects or infant eye infections
  - c. Report cancer diagnoses and tumors
  - d. Report child abuse and neglect or a child born with alcohol or other substances in their system
  - e. Report reactions to medications or problems with products
  - f. Notify people of recalls of products they may be using
  - g. Notify the Oklahoma Department of Health that a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition such as HIV, Syphilis, or other sexually transmitted diseases
  - h. Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence, if you agree or when required by law
16. **Health Oversight Activities:** We may disclose **PHI** to a health oversight agency for activities necessary for the government to monitor the health care system, government programs, and compliance with applicable laws. These oversight activities include, for example, audits, investigations, inspections, medical device reporting and accreditation.
17. **Lawsuits and Disputes:** If you are involved in a lawsuit or dispute, we may disclose **PHI** about you in response to a court or administrative order. We may also disclose **PHI** about you in a response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or obtain an order protecting the information requested.
18. **Law Enforcement:** We may release **PHI** if asked to do so by a law enforcement official:
  - a. In response to a court order, subpoena, warrant, summons, or similar process
  - b. To identify or locate a suspect, fugitive, material witness, or missing person
  - c. About the victim of a crime, if, under certain limited circumstances, we are unable to obtain the person's agreement
  - d. About a death we believe may be the result of criminal conduct
  - e. About criminal conduct at the clinic
  - f. In emergency circumstances to report a crime, the location of the crime or victims; or the identity description or location of the person who committed a crime
19. **Coroners, Medical Examiners, and Funeral Directors:** We may release **PHI** to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release **PHI** about patients of the clinic to funeral directors, as necessary to carry out their duties.



20. **National Security and Intelligence Activities:** We may release **PHI** about you to authorize federal officials for intelligence, counterintelligence, and other national security activities as authorized by law.
21. **Inmates:** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release **PHI** about you to the correctional institution or law enforcement official. This release would be necessary (1) for the correctional institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Your Rights Regarding Protected Health Information about You

You have the following rights regarding **PHI** we maintain about you:

1. **Right to Inspect and Copy:** You have the right to inspect and request a copy of your **PHI**, except as prohibited by law. To inspect and/or request a copy of your **PHI** that may be used to make decisions about you, you must submit your request in writing. If you request a copy of the information, we may charge a fee of .50 cents per page to offset the costs associated with the request. *We may deny your request to inspect and copy in certain circumstances. If you are denied access to certain **PHI**, you may request that the denial be reviewed. Another licensed health care professional chosen by the clinic will review your request and the denial. The person conducting the review will not bet the person who denied your request. We will comply with the outcome of the review.*
2. **Right to Amend:** If you feel the **PHI**, we have about you is incorrect or incomplete, you may ask to amend the information. You have the right to request an amendment as long as the information is kept by or for the clinic. To request the amendment, your request must be made in writing and state the reason for the request.

We may deny your request for any 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 us, unless the person or entity that created the information is no longer available to make the amendment
  - Is not part of the **PHI** kept by or for the clinic
  - Is not part of the information which you would be permitted to inspect or copy
  - Is accurate and complete
3. **Right to an Accounting Disclosure:** You have the right to request one free accounting disclosure every 12 months of the disclosure we made of **PHI** about you. To request this list, you must submit your request in writing. Your request must state a period which may not be longer than six years and may not include a date prior to April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). For additional lists, we may charge you for the cost of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
4. **Right to Request Restrictions:** You have the right to request a restriction or limitation on your **PHI** we use or disclose about you for treatment, payment, or healthcare operations. You also have the right to request a limit on the **PHI** we disclose about you to someone who is involved in



your care or the payment of your care, like a family member or friend. For example, you could ask that we not use or disclose information about a test that was performed. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. **To request restrictions**, you must make your request in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosures, or both; and (3) to whom you want the limitation to apply.

5. **Right to Communication by Alternative Means:** you have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing. We will not ask the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
6. **Health Data Sharing:** Fairfax Medical Facilities, Inc. may collect or disclose your **PHI** to a data sharing consortium, independent of the clinic, to provide accurate and more complete medical histories. The data sharing consortium will properly safeguard your privacy and the confidentiality of your **PHI**. Records received or shared may be used to help make medical decisions. You may choose **not** to participate by completing an "Opt Out" form available from our front desk receptionist.
7. **Right to Paper Copy of the Notice:** You have the right to a paper copy of this Notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. **To obtain a paper copy of this notice, please ask one of our staff members or write to:**

Privacy Officer  
Fairfax Medical Facilities, Inc.  
212 N. Main Street  
Fairfax, OK 74637  
918-642-3100

### **Changes to this Notice**

We reserve the right to change this notice. We reserve the right to make revised or changed notice effective for protected health information we already have about you as well as any information we receive in the future. We will provide a copy of the current Notice in the clinic. The Notice will contain on the first page, near the top, the effective date. In addition, each time you register at the clinic for treatment or health care services we will make available to you a copy of the current notice in effect.

### **Authorization for Other Uses of Protected Health**

Other users and disclosures of **PHI** not covered by this notice or the laws that apply to us will be made only with your written authorization. If you provide us authorization to use or disclose **PHI** about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose **PHI** about you for the reasons covered by your written authorization. You



understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care that we provided to you.

### **Complaints**

If you believe your privacy rights have been violated, you may file a written complaint with the clinic or with the Secretary of the department of Health and Human Services.

To file a complaint with the clinic, please write to:

Director of Nursing  
Fairfax Medical Facilities, Inc.  
212 N. Main Street  
Fairfax, OK 74637  
918-642-3100

To file a complaint with the Secretary of the Department of Health and Human Services, please write to:

The U.S. Department of Health and Human Services  
200 Independence Avenue, S.W.  
Washington, D.C. 20201  
[HHS.Mail@hhs.gov](mailto:HHS.Mail@hhs.gov)

The complaint to the Secretary must be filed within 180 days of when the complainant knew or should have known that the act of omission complained of occurred. The complaint must be in writing, either on paper or electronically, name the entity that is the subject of the complaint, and describe the act or acts of omission believed to be in violation of the standards.

You will not be penalized for filing a complaint.