

Everett Ear, Nose and Throat Inc.

NOTICE OF PRIVACY PRACTICES (HIPAA RULES)

Effective: February 2005

This document describes the type of information *Everett Ear, Nose and Throat, Inc.* gathers about you, with whom that information may be shared, and the safeguards we have in place to protect it. You have the right to the confidentiality of your medical information and the right to approve or refuse the release of specific information except when the release is required by law. If the practices described in this notice meet your expectations, there is nothing you need to do. If you prefer that we not share information, we may honor your written request in certain circumstances described below.

Who Will Follow This Notice?

This notice describes *Everett Ear, Nose and Throat, Inc.* and that of:

- Any health care professional authorized to enter information in your chart,
- All departments and units of Providence Medical Center, its clinics and other affiliates,
- Any member of a volunteer group we allow to help you while you at *Everett Ear, Nose and Throat, Inc.*,
- All employees, staff and other facility personnel.

All of these entities, sites and locations follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for the purposes of treatment, payment or healthcare operations described in this notice.

Our Pledge Regarding Medical Information

We understand that medical information about you and your health is personal. We are committed to protecting the confidentiality of your medical information. As part of our routine operations, we create a record of the care and services you receive. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by *Everett Ear, Nose and Throat, Inc.*, whether made by our personnel or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in that doctor's office or clinic.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

- Right to a Paper Copy of This 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.

Changes to this Notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain on the first page the effective date. In addition, each time you register at or are admitted to this facility for treatment or health care services as a patient, we will offer you a copy of the current notice in effect.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with *Everett Ear, Nose and Throat, Inc.*, or with the Secretary of the Department of Health and Human Services. All complaints to *Everett Ear, Nose and Throat, Inc.* must be submitted in writing. *You will not be penalized for filing a complaint.*

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information 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 permission, and that we are required to retain our records of the care that we provided to you.

Attestation

My signature below on this form means that I acknowledge that I have read a copy of the *Everett Ear, Nose and Throat, Inc.* PRIVACY NOTICE.

Signed: _____ Date: _____

Everett Ear, Nose and Throat, Inc.

Notice of PRIVACY PRACTICES – Acknowledgement

We keep a record of the health care services we provide to you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the Privacy Officer or the Practice Manager.

Our *Notice of Privacy Practices* describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below, I acknowledge **receipt** of the *Notice of Privacy Practices*.

PRINT - Patient Name

SIGNATURE – Patient or legally authorized individual Date

If you are **NOT** the patient, please indicate relationship to patient (spouse, parent, guardian, etc.)

This form will be retained in your medical record.
Last update: 2/22/05