

Notice of Privacy Practices

THIS NOTICE WHICH IS EFFECTIVE AS OF April 14, 2003, DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The doctors and staff here at Ohio Heart & Vascular Consultants believe your medical information should remain confidential. The law requires us to establish office policies that are designed to safeguard your health information. The information contained in this notice constitutes our promise to you that we acknowledge our legal obligation to protect your health information, and it describes your rights concerning our use of your health information.

We will use and disclose your health information for purposes of treatment, payment and/or health care operations.

1. Treatment means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another. For example, a consultation follow up letter from a specialist to your primary care physician would be medical information maintained for treatment purposes.
2. Payment means activities undertaken by a covered health care provider or health plan to obtain or provide reimbursement for the provision of health care. For example, the medical information furnished to your insurance company so that we may be paid for our services is considered information maintained for payment purposes.
3. Health Care Operations includes certain activities of the practice, as well as activities of an organized health care arrangement in which we participate, including: quality assessment and improvement activities, reviews of the competence or qualifications of health care professionals, activities related to underwriting or premium rating of insurance contracts, activities related to legal or accounting services provided to the practice, and business management and planning. For example, from time to time hospitals and insurance companies will review physicians' clinical skills in order to assure that quality care is being provided. When such reviews are conducted, it is often necessary for the reviewer to randomly select and examine patients' medical records.

We are permitted or required to disclose limited health information about you, without your authorization, in the following circumstances:

1. As required by law so long as it is limited to the relevant requirements of such law.
2. For public health activities, including the prevention and control of disease, vital statistics, and public health investigations.
3. For purposes of making required reports about victims of abuse, neglect, or domestic violence.
4. Health oversight activities, including audits, civil, criminal or administrative investigations, proceedings or actions; inspections; licensure or disciplinary actions.
5. Judicial and administrative proceedings, in response to court orders.
6. Law enforcement purposes (i.e. reports of gunshot wounds; grand jury subpoenas; and information regarding victims of crime).
7. To coroners, medical examiners and funeral directors for purposes of identifying deceased persons or determining cause of death.
8. For organ and tissue donation, consistent with applicable laws.
9. Research, provided the federal regulations governing research activities that insure the privacy of your health information are met.
10. To avert serious threats to health or safety.
11. Specialized government functions regarding military personnel and military veterans, certain national security purposes, and inmates.
12. Workers' compensation to the extent necessary to comply with applicable laws.
13. Marketing, for purposes of appointment reminders, treatment alternatives, or other related benefits and services that may be of interest to you.

Any uses or disclosures other than those noted above require us to obtain your written authorization, which you may revoke at any time. Any such revocation must be in writing.

Contact and Authorization of Release of Information

Patient Name

____/____/____
Date of Birth

I wish to be contacted in the following manner (check all that apply):

Oral Communication:

- | | |
|--|--|
| <input type="checkbox"/> Home Telephone _____ | <input type="checkbox"/> Work Telephone _____ |
| <input type="checkbox"/> OK to leave message with detailed information | <input type="checkbox"/> OK to leave message with detailed information |
| <input type="checkbox"/> Leave message with call-back number only | <input type="checkbox"/> Leave message with call-back number only |

Written Communication:

- | | |
|---|--|
| <input type="checkbox"/> OK to mail to my home address | <input type="checkbox"/> OK to fax to this number (____) ____-____ |
| <input type="checkbox"/> OK to mail to my work/office address | <input type="checkbox"/> Other _____ |

I permit the Practice to discuss my PHI with, and disclose my PHI to the following individuals:

- Spouse _____
- Adult Child(ren) _____
- My Parents _____
- Personal representative _____

If checked, the following additional instructions apply:

Patients Signature

____/____/____
Date

- If signed by patient's authorized representative, describe the representative's authority:
- Patient is a minor, I am the patient's parent and natural guardian
- Patient is a minor, I am the patient's guardian, appointed by the _____ County Juvenile Court
- Patient is a ward, I am the patient's guardian, appointed by the _____ County Probate Court
- Patient is deceased, I am the patient's surviving spouse
- Patient is deceased, I am the patient's executor or administrator of the patients estate, appointed by the _____ County Probate Court
- I am the patient's attorney in fact, as designated in the patients' Durable Power of Attorney for Health Care.
- Other (describe) _____