Health Insurance Portability and Accountability Act (HIPAA)
Notice of Privacy Practices Form

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This clinic is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

HEALTH INFORMATION THAT WE MAINTAIN ABOUT YOU:

We maintain records of:

- Your name and (if different) the name and relationship of the person receiving treatment
- Your billing address
- Your telephone number
- Your (or the patient's, if different) condition that brings you here to the Pregnancy Clinic
- The date the professional health care provider reviewed your chart with you
- Clinical findings related to the condition such as test results of Urine Pregnancy Tests, Limited Ultrasound, and any other diagnostic or monitoring test to ensure your safety.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the right to:

- Request restrictions on certain uses and disclosures
- Receive communications of protected health information by alternative means or at alternative locations.
- Inspect, copy, and amend your protected health information held at the Pregnancy Clinic; receive an accounting of certain disclosures (of your protected health information)
- Receive a paper copy of this notice even if you have received it electronically

HOW WE USE AND DISCLOSE YOUR HEALTH INFORMATION

We only use or disclose your health information as state and federal laws require or permit. In some cases, the law requires that you authorize the disclosure. In other cases, the law allows us to disclose your health information without your authorization.

Use and Disclosure Not Requiring Your Authorization

Treatment: We may use your health information for our treatment activities, such as disclosing it to other healthcare providers as helpful to treat you.

Payment: (All services at this clinic are currently performed without charge and we therefore do not bill insurance.) We may disclose your health information to your insurance provider for the purpose of payment of health care operations.

Healthcare Operations: We may use and disclose your health information to manage our program operations, such as reviewing the quality of services you receive.

Business Associates: We may disclose your health information to organizations that help us with our work. We have a written agreement that requires these organizations to use your health information for only the reasons necessary to do the work, and protect it from other users, or disclosures, just like we do.

To Contact You: We may use the information in your health records to contact you if we have information about treatment or other health-related benefits and services that may be of interest to you ***and only if you have given us permission to contact you.***

Other Permitted Uses and Disclosures

HIPAA specifically permits us to use or disclose your health information for other purposes without your consent or authorization. In our experience such disclosures are rare, and the limited information we maintain is generally not applicable. However, when authorized by law, and to the extent we may have the information, HIPAA permits us to disclose to:

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- Comply with the requirements of federal, state, or local laws, court orders, or other lawful process and for administrative or court proceedings.
- Report to a public health authority for the purpose of preventing or controlling disease, injury, or disability
- Report to the FDA for the quality, safety or effectiveness of FDA-regulated products or activities
- Notify 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
- Report abuse, neglect or domestic violence to a government authority
- Provide necessary information to a health oversight agency for activities such as audits, investigations, inspections, licensure of the healthcare system, government benefit programs and regulated entities
- A law enforcement official for specified law enforcement purposes
- Coroners or medical examiners for identification or determining cause of death
- Funeral directors to carry out their duties with respect to the decedent
- Organ procurement organizations for facilitating donation and transplantation
- Researchers conducting studies approved by an Institutional Review Board
- Prevent or lesson a serious an imminent threat to the health and safety of a person or the public
- Authorized federal officials for specialized government functions such as military and veterans activities; national security and intelligence activities; protective services for the president; medical suitability determinations; correctional institutions; government entities providing public benefits; and
- Comply with workers' compensation laws

USES AND DISCLOSURES WITH YOUR AUTHORIZATION

Other uses and disclosures or your personal information require your written authorizations. You may revoke your authorization at any time by doing so in writing.

HOW YOU CAN REACH US

If you have questions about any part of this notice or if you want more information about your privacy rights, please call this office at 760-369-8512 and ask for the Executive Director.

COMPLAINTS

Complaints about your privacy rights or about how this clinic has handled your heath information should be directed to the Executive Director by calling the office at 760-369-8512. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to: Office for Civil Rights, US Department of Health & Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Bldg., Washington, D.C. 20201.

HIPAA Consent

I have read the **HIPAA Notice of Privacy Practices** and understand my rights contained in the notice. By way of my signature, I provide this clinic with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operation as described in the **HIPAA Notice of Privacy Practices.**

Client's Name – **Print** _____ Date _____

Client's Signature _____ Date _____

Clinic Representative's Signature _____ Date _____