

D. Neal Mastruserio, M.D., LLC
3380 Tremont Road, Suite 140
Columbus, Ohio 43221
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NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the
Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). We will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you and to provide you with this notice of our legal duties and the privacy practices that we maintain. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS:

Treatment. Our practice may use your IIHI to treat you. We may ask you to have laboratory tests and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you and give your IIHI to a pharmacy when we order a prescription for you. We may provide your IIHI to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.

Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. A hospital stay may require that your relevant IIHI be disclosed to the health plan to obtain approval for the hospital admission. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items.

Healthcare Operations. Our practice may use and disclose your IIHI to operate our business. We may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations. We may use and disclose your IIHI to inform you of potential treatment options or alternatives. Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. In addition, we will have a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your physician is ready to see you. We may use and disclose your IIHI to contact you and remind you of an appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health of Human Services to investigate or determine our compliance with the Requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made ONLY with your consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician has taken action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. Your request must describe in a clear and concise fashion: the information you wish restricted; whether you are requesting to limit our practice's use, disclosure or both; and to whom you want the limits to apply.

Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records. You must submit your request in writing in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment, non-payment or non-operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time.

Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact **Candy Dillon, Office Manager, 3380 Tremont Road, Ste. 140, Columbus, Ohio 43221, 614-442-6647**. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time **in writing**. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note that we are required to retain records of your care.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization. Please contact **Candy Dillon, Office Manager, 3380 Tremont Road, Ste. 140, Columbus, Ohio 43221, 614-442-6647**.

This notice was published and becomes effective on/or before April 14, 2003.

D. Neal Mastruserio, M.D., LLC

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**Receipt of Notice of Privacy Practices
Written Acknowledgement Form**

Signature below is only an acknowledgement that you have received this Notice of our Privacy Practices:

I, _____, have received a copy of D. Neal Mastruserio, M.D., LLC's
Notice of Privacy Practices.

Signature of Patient

Date