

# HEALING HANDS THERAPY CENTER, LLC

## Notice of Privacy Practices

Effective Date: June 21, 2018

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

If you have any questions about this notice, please contact our privacy officer:

Heather Mogielnicki  
111 Main Street  
Collinsville, CT 06019  
860-404-2587

**1. Summary of Rights and Obligations Concerning Health Information.** Healing Hands Therapy Center, LLC is committed to preserving the privacy and confidentiality of your health information, which is required both by federal and state law. Healing Hands Therapy Center is required by law to provide you with this notice of our legal duties, your rights, and our privacy practices, with respect to using and disclosing your health information that is created or retained by Healing Hands Therapy Center, LLC. Each time you visit, a record is made of your visit. Typically, this record contains your symptoms, examination and test results, our assessment of your condition, a record of your treatment interventions, and a plan for future care or treatment. Healing Hands Therapy Center has an ethical and legal obligation to protect the privacy of your health information, and will only use or disclose this information in limited circumstances. In general, I may use and disclose your health information to:

- plan your care and treatment;
- provide treatment by us or others;
- communicate with other providers such as referring physicians;
- receive payment from you, your health plan, or your health insurer;
- make quality assessments and work to improve the care we render and the outcomes we achieve, known as health care operations;
- make you aware of services and treatments that may be of interest to you; and
- comply with state and federal laws that require us to disclose your health information.

I may also use or disclose your health information where you have authorized me to do so.

Although your health record belongs to Healing Hands Therapy Center, LLC the information in your record belongs to you. You have the right to:

- ensure the accuracy of your health record;
- request confidential communications between you and your physician and request limits on the use and disclosure of your health information; and
- request an accounting of certain uses and disclosures of health information we have made about you.

Healing Hands Therapy Center is required to:

- maintain the privacy of your health information;
- provide you with notice, such as this *Notice of Privacy Practices*, as to our legal duties and privacy practices with respect to information we collect and maintain about you;
- abide by the terms of our most current *Notice of Privacy Practices*;
- notify you if we are unable to agree to a requested restriction; and
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

**Healing Hands Therapy Center reserves the right to change it's practices and to make the new provisions effective for all your health information that is maintained.**

Should the information practices change, a revised *Notice of Privacy Practices* will be available upon request. If there is a material change, a revised Notice of Privacy Practices will be distributed to the extent required by law. Healing Hands Therapy Center will not use or disclose your health information without your authorization, except as described in the most

current *Notice of Privacy Practices*. In the following pages, we explain our privacy practices and your rights to your health information in more detail.

**2. I may use or disclose your medical information in the following ways:**

- A. *Treatment.*** I may use and disclose your protected health information to provide, coordinate and manage your rehab care. That may include consulting with other health care providers about your health care or referring you to another health care provider for treatment including physicians, nurses, and other health care providers involved in your care. For example, I may release your protected health information to a specialist to whom you have been referred to ensure that the specialist has the necessary information he or she needs to diagnose and/or treat you.
- B. *Payment.*** I may use and disclose your health information so that I may bill and collect payment for the services that I provided to you. For example, I may contact your health insurer to verify your eligibility for benefits, and may need to disclose to it some details of your medical condition or expected course of treatment. I may use or disclose your information so that a bill may be sent to you, your health insurer, or a family member. The information on or accompanying the bill may include information that identifies you and your diagnosis, as well as services rendered, any procedures performed, and supplies used. Also, I may provide health information to a collection agency, small claims court or other court of competent jurisdiction in the event your claims for our services are not paid within 90 days and you have not made alternative payment arrangements with me.
- C. *Health Care Operations.*** I may use and disclose your health information to assist in the operation of my practice. For example, members of my staff may use information in your health record to assess the care and outcomes in your case and others like it as part of a continuous effort to improve the quality and effectiveness of the healthcare and services I provide. I may use and disclose your health information to conduct cost-management and business planning activities for my practice. I may also provide such information to other health care entities for their health care operations. For example, I may provide information to your health insurer for its quality review purposes.
- D. *Students.*** Student/interns in rehabilitation or health service related programs work in my facility from time to time to meet their educational requirements or to get health care experience. These students may observe or participate in your treatment or use your health information to assist in their training. You have the right to refuse to be examined, observed, or treated by any student or intern. If you do not want a student or intern to observe or participate in your care, please notify your provider.
- E. *Business Associates.*** *Healing Hands Therapy Center, LLC* sometimes contracts with third-party business associates for services. Examples include answering services, transcriptionists, billing services, consultants, and legal counsel. I may disclose your health information to my business associates so that they can perform the job I have asked them to do. To protect your health information, however, I require our business associates to appropriately safeguard your information.
- F. *Treatment Options.*** I may use and disclose your health information in order to inform you of alternative treatments.
- G. *Release to Family/Friends.*** My staff, using their professional judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, your health information to the extent it is relevant to that person's involvement in your care or payment related to your care. I will provide you with an opportunity to object to such a disclosure whenever I practicably can do so. I may disclose the health information of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law. However, please note that under CT state law, if a child age 14 or older requests that their medical information not be disclosed to a parent or guardian, I must comply with their request. Please let your provider know if you would not like me to release information to a family member or friend.
- H. *Newsletters and Other Communications.*** I may use your personal information in order to communicate to you via newsletters (including electronic newsletters), mailings, or other means regarding treatment options, health related information, disease management programs, wellness programs, or other community based initiatives or activities in which our practice is participating.
- I. *Disaster Relief.*** I may disclose your health information in disaster relief situations where disaster relief organizations seek your health information to coordinate your care, or notify family and friends of your location and condition. I will provide you with an opportunity to agree or object to such a disclosure whenever I practicably can do so.

- J. Marketing and Sale of Health Information.** I am required by law to obtain your written authorization before I use or disclose your health information to send you marketing communications about products or services offered by third parties where I have received financial remuneration from the third party for such communications. However, I do not have to obtain your written authorization to discuss services or products offered by third parties in face-to-face communications or to offer promotional gifts of nominal value. For example, if a massage therapist wants to pay us for a list of names and addresses of our patients to send a solicitation for the massage therapist's services, I will obtain your written authorization before disclosing your information. I do not have to obtain your written authorization before discussing, face-to-face, the massage therapist's services with you. Under no circumstances will I sell your health information without your written authorization.
- K. Fundraising.** I may use certain information (name only, address, telephone number, date of service, age and gender) to contact you as part of fundraising efforts our practice participates in. If you do not wish to be contacted about our fundraising activities, please notify your provider or our privacy officer.
- L. Public Health Activities.** I may disclose medical information about you for public health activities. These activities generally include the following:
- licensing and certification carried out by public health authorities;
  - prevention or control of disease, injury, or disability;
  - reports of births and deaths;
  - reports of child abuse or neglect;
  - notifications to people who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
  - organ or tissue donation; and
  - notifications to appropriate government authorities if I believe a patient has been the victim of abuse, neglect, or domestic violence. I will make this disclosure when required by law, or if you agree to the disclosure, or when authorized by law and in our professional judgment disclosure is required to prevent serious harm.
- M. Health Oversight.** I may disclose health information to regulatory agencies of the federal and state government relating to actions required by law, such as audits, investigations, inspections and licensure. These actions are needed for the government to monitor the healthcare system, programs, and compliance with civil rights laws.
- N. Research.** I may disclose your health information to researchers when the information does not directly identify you as the source of the information or when a waiver has been issued by an institutional review board or a privacy board that has reviewed the research proposal and protocols for compliance with standards to ensure the privacy of your health information.
- O. Workers Compensation.** I may disclose your health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.
- P. Law Enforcement.** I may release your health information:
- in response to a court order, subpoena, warrant, summons, or similar process of authorized under state or federal law;
  - to identify or locate a suspect, fugitive, material witness, or similar person;
  - about the victim of a crime if, under certain limited circumstances, I am unable to obtain the person's agreement;
  - about a death I believe may be the result of criminal conduct;
  - about criminal conduct at [name of provider];
  - to coroners or medical examiners;
  - 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 the crime;
  - to authorized federal officials for intelligence, counterintelligence, and other national security authorized by law; and
  - to authorized federal officials so they may conduct special investigations or provide protection to the President, other authorized persons, or foreign heads of state.
- Q. De-identified Information.** I may use your health information to create "de-identified" information or I may disclose your information to a business associate so that the business associate can create de-identified

information on our behalf. When I "de-identify" health information, I remove information that identifies you as the source of the information. Health information is considered "de-identified" only if there is no reasonable basis to believe that the health information could be used to identify you.

**R. Personal Representative.** If you have a personal representative, such as a legal guardian, I will treat that person as if that person is you with respect to disclosures of your health information. If you become deceased, I may disclose health information to an executor or administrator of your estate to the extent that person is acting as your personal representative.

**S. Limited Data Set.** I may use and disclose a limited data set that does not contain specific readily identifiable information about you for research, public health, and health care operations. I may not disseminate the limited data set unless we enter into a data use agreement with the recipient in which the recipient agrees to limit the use of that data set to the purposes for which it was provided, ensure the security of the data, and not identify the information or use it to contact any individual.

**3. Authorization for Other Uses of Medical Information.** Uses of medical information not covered by my most current *Notice of Privacy Practices* or the laws that apply to me will be made only with your **written authorization**. You should be aware that I am not responsible for any further disclosures made by the party you authorize me to release information to. If you provide me with authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, I will no longer use or disclose medical information about you for the reasons covered by your written authorization, except to the extent that I have already taken action in reliance on your authorization or, if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has the right to contest a claim or the insurance coverage itself. I am unable to take back any disclosures I have already made with your authorization, and I am required to retain our records of the care that I provided to you.

**4. Your Health Information Rights.** You have the following rights regarding medical information I gather about you:

**A. Right to Obtain a Paper Copy of This Notice.** You have the right to a paper copy of this Notice of Privacy Practices at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy.

**B. Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. This includes medical and billing records.

To inspect and copy medical information, you must submit a written request to your provider or our privacy officer. If you request a copy of your medical information, I may, subject to state law restrictions or limitations, charge a reasonable fee for the costs of labor, postage, and supplies associated with your request. I may not charge you a fee if you require your medical information for a claim for benefits under the Social Security Act (such as claims for Social Security, Supplemental Security Income, and any other state or federal needs-based benefit program).

If your medical information is maintained in an electronic health record, you also have the right to request that an electronic copy of your record be sent to you or to another individual or entity. I may charge you a reasonable cost based fee limited to the labor costs associated with transmitting the electronic health record.

**C. Right to Amend.** If you feel that medical information I have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as I retain the information.

To request an amendment, your request must be made in writing and submitted to your provider or our privacy officer. In addition, you must provide a reason that supports your request. I may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, I may deny your request if you ask me to amend information that:

- was not created by me, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the medical information kept by or for [name of provider];
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

If I deny your request for amendment, you may submit a statement of disagreement. I may reasonably limit the length of this statement. Your letter of disagreement will be included in your medical record, but I may also include a rebuttal statement.

**D. Right to an Accounting of Disclosures.** You have the right to request an accounting of disclosures of your health information made by me. In your accounting, I am not required to list certain disclosures, including:

- disclosures made for treatment, payment, and health care operations purposes or disclosures made incidental to treatment, payment, and health care operations, however, if the disclosures were made through an electronic health record, you have the right to request an accounting for such disclosures that were made during the previous 3 years;
- disclosures made pursuant to your authorization;
- disclosures made to create a limited data set;
- disclosures made directly to you.

To request an accounting of disclosures, you must submit your request in writing to the privacy officer. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you would like the accounting of disclosures (for example, on paper or electronically by e-mail). The first accounting of disclosures you request within any 12 month period will be free. For additional requests within the same period, I may charge you for the reasonable costs of providing the accounting of disclosures. I will notify you of the costs involved and you may choose to withdraw or modify your request at that time, before any costs are incurred. Under limited circumstances mandated by federal and state law, I may temporarily deny your request for an accounting of disclosures.

**E. Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information I use or disclose about you for treatment, payment, or health care operations. If you paid out-of-pocket for a specific item or service, you have the right to request that medical information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and I am required to honor that request unless I am required by law to disclose the information. You also have the right to request a limit on the medical information I communicate about you to someone who is involved in your care or the payment for your care.

Except as noted above, I am not required to agree to your request. If I do agree, I will comply with your request unless the restricted information is needed to provide you with emergency treatment. To request restrictions, you must make your request in writing to your provider or our privacy officer. In your request, you must tell me:

- what information you want to limit;
- whether you want to limit our use, disclosure, or both; and
- to whom you want the limits to apply.

**F. Right to Request Confidential Communications.** You have the right to request that I communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that I only contact you at work or by e-mail. To request confidential communications, you must make your request in writing to your provider or our privacy officer. I will not ask you the reason for your request. I will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

**G. Right to Receive Notice of a Breach.** I am required to notify you by first class mail or by e-mail (if you have indicated a preference to receive information by e-mail), of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days following the discovery of the breach. "Unsecured Protected Health Information" is information that is not secured through the use of a technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the Protected Health Information unusable, unreadable, and undecipherable to unauthorized users.

## 5. Complaints

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201. To file a complaint with us, contact our privacy officer at the address listed above. All complaints must be submitted in writing and should be submitted within 180 days of when you knew or should have known that the alleged violation occurred. See the Office for Civil Rights website, [www.hhs.gov/ocr/hipaa/](http://www.hhs.gov/ocr/hipaa/) for more information. You will not be penalized for filing a complaint.