Joseph C. & Ann S.
DAY PRIMARY CARE

NOTICE OF PRIVACY PRACTICES

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

Our duties. The law requires us to protect the privacy of your health information, give you this notice, follow it, and tell you if a breach affects your information.

How we use and share your information. *Treatment:* with specialists, hospitals, pharmacies, and home health agencies involved in your care. *Payment:* to bill Medicare, Medicaid, and other health plans. *Operations:* to run our practice, manage your care, review quality, and train staff. We may also send appointment reminders and health-related information, and share with business associates who agree in writing to protect it.

Other uses the law allows or requires. Public health and safety; reporting suspected abuse, neglect, or exploitation; health oversight and audits; court orders and subpoenas; law enforcement; coroners and funeral directors; organ donation; research; workers' compensation; military and national security; and as otherwise required by law. We follow stricter laws that protect HIV, mental health, and substance use disorder records.

Your choices. Unless you tell us not to, we may share information with family or caregivers involved in your care, and with disaster relief organizations. *Fundraising:* As a nonprofit, the Council on Aging of Martin County may use your name and contact information. You may opt out of fundraising communications at any time. Just let our staff know. Opting out will not affect your care in any way.

Uses that need your written permission. Marketing, sale of your information, most sharing of psychotherapy notes, and any use not described here. You may revoke your permission in writing at any time.

Your rights. You may get a copy of your record (usually within 30 days; a reasonable fee may apply); ask us to correct it; ask us to contact you in a certain way or at a certain address; ask us to limit what we share (if you pay in full out of pocket, we will not share that service with your health plan); get a list of certain disclosures from the past six years; get a paper copy of this notice; and name a representative, such as a health care surrogate or power of attorney, to act for you.

Changes and complaints. We may change this notice, and changes will apply to all information we hold; the current notice is posted in our office and on our website. If you believe your privacy rights were violated, contact our Privacy Officer or the U.S. Department of Health and Human Services Office for Civil Rights (1-877-696-6775, hhs.gov/ocr/complaints). **We will not retaliate against you for filing a complaint.**

Privacy Officer: Adam Levenson · 772-223-7800

Joseph C. & Ann S.
DAY PRIMARY CARE

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

SIGNATURE REQUIRED ON THIS FORM

I acknowledge that I have received a copy of the Council on Aging of Martin County — Day Primary Care Notice of Privacy Practices.

Patient name (print): _____

Date of birth: _____

Signature of patient or legal representative: _____

Date: _____

If signed by a legal representative, relationship / authority (health care surrogate, POA, guardian):

_____