

April, 14, 2003

**LEXINGTON CARDIOLOGY CONSULTANTS**

1720 Nicholasville Road  
Lexington, Kentucky 40503-1424

**859-277-5887 OR 800-999-3421,**

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**NOTICE OF PRIVACY PRACTICES**

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

If you have any questions about this notice, please contact the **Privacy Officer**

**CHANGES TO THIS NOTICE**

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

**COMPLAINTS**

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our **Privacy Officer** about this notice.

You will not be penalized for filing a complaint.

## **WHO WILL FOLLOW THIS NOTICE**

This notice describes the information privacy practices followed by our employees, staff and other office personnel. The practices described in this notice will also be followed by health care providers you consult with by telephone (when your regular health care provider from our office is not available) who provide "call coverage" for your health care provider.

## **YOUR HEALTH INFORMATION**

This notice applies to the information and records we have about your health, health status, and the health care and service(s) you receive at this office. We are required by law to provide you with this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

### HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

**For Treatment** We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health. For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you. Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have. **For Payment** We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment. **For Health Care Operations** We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective. **Appointment Reminders** We may contact you as a reminder that you have an appointment for treatment or medical care at the office. **Treatment Alternatives** We may tell you about or recommend possible treatment options or alternatives that

may be of interest to you. **Health-Related Products and Services** We may tell you about health-related products or services that may be of interest to you. Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-related products and services. If you advise us in writing (at the address listed at the top of this Notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes. You may revoke your *Consent* at any time by giving us written notice. Your revocation will be effective when we receive it, but it will not apply to any uses and disclosures, which occurred before that time. If you do revoke your *Consent*, we will not be permitted to use or disclose information for purposes of treatment, payment or health care operations, and we may therefore choose to discontinue providing you with health care treatment and services.

**SPECIAL SITUATIONS** We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations: **To Avert a Serious Threat to Health or Safety** We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. **Required By Law** We will disclose health information about you when required to do so by federal, state or local law. **Research** We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office. **Organ and Tissue Donation** If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation. **Military, Veterans, National Security and Intelligence** If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority. **Workers' Compensation** We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness. **Public Health Risks** We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products. **Health Oversight Activities** We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws. **Lawsuits and Disputes** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information

about you in response to a subpoena. **Law Enforcement** We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements. **Coroners, Medical Examiners and Funeral Directors** We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. **Family and Friends** We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed. In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies, or X-rays.

#### **OTHER USES AND DISCLOSURES OF HEALTH INFORMATION**

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization*. We must obtain your *Authorization* separate from any *Consent* we may have obtained from you. If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization*, in writing, at any time. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission. If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization (different than the *Authorization* and *Consent* mentioned above) from you. In order to disclose these types of records for purposes of treatment, payment or health care operations, we will have to have both your signed *Consent* and a special written *Authorization* that complies with the law governing HIV or substance abuse records.

#### **YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU**

You have the following rights regarding health information we maintain about you. **Right to Inspect and Copy** You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to our **Privacy Officer** in order

to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If law requires such a review, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review. **Right to Amend** If you believe health information we have about you is incorrect or incomplete; you may ask us to amend the information. You have the right to request an amendment as long as this office retains the information. To request an amendment, complete and submit a Medical Record Amendment/Correction Form to our **Privacy Officer**. We 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, we may deny your request if you ask us to amend information that: a) We did not create, unless the person or entity that created the information is no longer available to make the amendment. .b) Is not part of the health information that we retain. c) You would not be permitted to inspect and copy. d) Is accurate and complete. **Right to an Accounting of Disclosures** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and health care operations. To obtain this list, you must submit your request in writing to our **Privacy Officer**. It 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 want the list (for example, on paper, electronically). We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred **Right to Request Restrictions** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. **We are Not Required to Agree to Your Request** If we do agree; we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you may complete and submit *the Request For Restriction On Use/Disclosure Of Medical Information* to our **Privacy Officer**.

**Right to Request Confidential Communications** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you may complete and submit the *Request For Restriction On Use/Disclosure Of Medical Information And/Or Confidential Communication* to our **Privacy Officer**. We will not ask you the reason for your

request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

**Consent for Purposes of Treatment, Payment and Health Care Operations**

I consent to the use or disclosure of my protected health information by **Lexington Cardiology Consultants** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **Lexington Cardiology Consultants**.

I understand that diagnosis or treatment of me by **Lexington Cardiology Consultants** may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. **Lexington Cardiology Consultants** is not required to agree to the restrictions that I may request. However, if **Lexington Cardiology Consultants** agrees to a restriction that I request, the restriction is binding on **Lexington Cardiology Consultants** and any healthcare provider of **Lexington Cardiology Consultants**.

I have the right to revoke this consent, in writing, at any time, except to the extent that **Lexington Cardiology Consultants** or any healthcare provider of **Lexington Cardiology Consultants** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a healthcare clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review **Lexington Cardiology Consultants'** Notice of Privacy Practices prior to signing this document.

The **Lexington Cardiology Consultants' Notice of Privacy Practices** has been provided to me.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the **Lexington Cardiology Consultants**.

The **Notice of Privacy Practices** for **Lexington Cardiology Consultants** is also provided **in the office where Notice of Privacy Practices is posted** and on the **Lexington Cardiology Consultant's** web site at [www.lexingtoncardio.com](http://www.lexingtoncardio.com)

This **Notice of Privacy Practices** also describes my rights and the duties of **Lexington Cardiology Consultants** with respect to my protected health information.

**Lexington Cardiology Consultants** reserves the right to change the privacy practices that are described in the **Notice of Privacy Practices**.

I may obtain a revised notice of privacy practices by accessing the **Lexington Cardiology Consultants'** web site, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

\_\_\_\_\_ Signature of Patient or Personal Representative  
\_\_\_\_\_ Print Name of Patient or Personal Representative      Date: \_\_\_\_\_

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Description of Personal Representative's Authority

**NOTE:**

- If you are not available when we call, may we have your permission to leave a message either on your answering machine or with another person? YES \_\_\_\_\_ NO \_\_\_\_\_
- Please list the names of family members or friends that we may discuss your care with and identify their relationship to you:

<u>NAME</u>	<u>RELATIONSHIP</u>
_____	_____
_____	_____
_____	_____

**ACKNOWLEDGEMENT OF RECEIPT**

**OF**

**LEXINGTON CARDIOLOGY CONSULTANTS  
NOTICE OF PRIVACY PRACTICES**

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so chose) and understood the Notice.

Patient Name: (please print) \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Parent or Authorized Representative (if applicable)