HIPAA Notice of Privacy Practices
as conducted by Friendship Medical Center, P.A.

"HIPAA" is the 1996 Health Insurance Portability and Accountability Act that charges health care providers and health care organizations with the responsibility of including you ("you" being the patient or patient representative) in the control of who may view and who may not view your medical records (your protected health information "PHI"). PHI includes, but is not limited to: lab results, radiology results, medical records, hospital notes, and demographic data.

For the original HIPAA document, please see P.L. 104-191, 42 U.S.C. Section 1320d, et. Seq.

I. OUR RESPONSIBILITIES

Friendship Medical Center is required by law to maintain the privacy of your Protected Health Information (PHI) and to provide you with this Notice that explains how, when, and why we use and disclose your PHI. We are required by law to follow the privacy practices that are described in this Notice. We reserve the right to change this Notice and our privacy policies at any time. Any such changes will apply to the PHI we already have. Before we make an important change to our policies, we will change this Notice and post a new notice in our office. You can also request a copy of this Notice or any revised notice from the contact person listed in Section V. below at any time.

II. HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION:

Friendship Medical Center uses and discloses the PHI of its patients for many different reasons. In this Notice, to "use" PHI means that we are sharing that information with someone who is a member of Friendship Medical Center's workforce, including consultants involved in your health care. Some disclosures require your prior consent or specific authorization, and others do not.

Situations in which we will release or share PHI without your prior written consent:

A. ***For Treatment Purposes*** *We may share your PHI in the course of providing, coordinating or managing your health care needs. This means that all healthcare personnel involved in your care may have access to your PHI. For example, if Dr. Troy refers you to a specialist for evaluation, testing and treatment, we will share protected health information with that specialist.*

B. ***Disclosures of Your Protected Health Information for Payment Purposes Require Your Prior Written Consent.*** *North Carolina law requires us to get your written consent to the disclosure of your protected health information for payment purposes. If you are an existing patient, you have already signed a consent allowing us to share your protected health information with your health insurance company If you are a new patient, you will be asked to sign consent during your first visit with us. Other than an emergency situation, we can refuse treatment to any patient who does not sign a consent allowing us to share protected health information with his or her insurance company or any other person or entity responsible for paying for your healthcare services. For example, after obtaining your consent, we may send your health insurance company a copy of your physician's notes to show that the tests you received were medically necessary and thus should be covered by the health insurance policy.*

C. ***Disclosures of Your Protected Health Information for our Healthcare Operations Requires Your Prior Written Consent.*** *North Carolina law requires us to get your written consent to the disclosure of your protected health information for our healthcare operations. We may want to use your protected health information in the operation of our practice for such purposes, among others, as developing procedures and protocols, reviewing the performance of your physician or other healthcare providers, training new physicians and other healthcare providers, business planning and development, and general administrative activities. Note that this list does not include every purpose for which we might use your protected health information for our healthcare operations. You will be asked to sign consent during your first visit with us on or after October 1, 2007. Other than emergency situations, we can refuse treatment to any patient who does not sign a consent allowing us to share protected*

health information for our healthcare operations. For example, after obtaining your consent, we may allow an independent consultant to review your medical record as part of risk management or billing compliance audit.

D. When disclosure is required by federal or local law, judicial or administrative proceedings, or law enforcement. *For example, victims of abuse or neglect, or gunshot or knife wounds must be reported.*

E. For public health activities to avert a serious threat to health and safety.

- *"Reportable Diseases" as defined by Centers For Disease Control; Examples: West Nile virus, Lyme Disease*
- *coroners, medical examiners, and funeral directors may need information relating to a person's death*
- *we may provide information to law enforcement or another person if we believe, in good faith, that the use or disclosure is necessary to prevent serious and imminent threat to the health or safety of a person or to the public.*

F. For health oversight activities. *For example, audits.*

G. For specialized government functions. *For example, national security activities authorized by law.*

H. Appointment Reminders and Health Related Benefits or service.

III. YOUR HEALTH INFORMATION RIGHTS:

Although your health record is the property of and belongs to Friendship Medical Center, you have the following rights with respect to you protected health information:

A. The Right to Request Restrictions on uses and Disclosures of Your Protected Health Information. *You have the right to ask us to limit how we use and disclose your protected health information. We will consider your request, but we are not legally required to accept it. If we do not accept your request, we will note the accepted limitations in writing and follow those restrictions except in emergency circumstances. You may not limit the uses and disclosures that we are legally required to make.*

B. The Right to Choose How We Send Protected Health Information. *You have the right to ask that we send information to you to an alternate address (for example, sending information to your home address instead of your work address) or by alternate means (for example, by e-mail instead of regular mail). If we can easily provide the information in the format you request, then we must agree to your request and abide by it.*

C. The Right to See and Get Copies of Your Protected Health Information. *In most cases you have the right to look at or get copies of your PHI. You must make any request to look at or get copies of your protected health information in writing to the contact person identified in section V. below. We will respond to you within 30 days after receiving your written request. In certain situations, we may deny your request. If we deny your request, we must tell you, in writing our reasons for denying your request and explain to you that you have the right to have our decision reviewed and how to start the review process. If you request copies of your PHI, we will charge fees as per North Carolina law.*

IV. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES:

If you think we have violated your privacy rights or you disagree with a decision we made about access to your protected health information, you may file a complaint with the person listed in Section V. below. You may also send a written complaint to the Secretary of the United States Department of Health and Human Services, 200 Independent Avenue, S.W., Washington, DC 20201. No adverse action will be taken by us against you for filing a complaint.

V. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES:

If you have any questions about this Notice or have any complaints about our privacy practices, or would like assistance, including the appropriate forms to use, in exercising ANY OF THE RIGHTS LISTED IN section III. above or would like to know how to file a complaint with the Secretary of the United States Department of Health and Human Services, please contact:

Cathy Asbill (Privacy Officer)
400 Ashville Avenue, Suite 340
Cary, NC 27518-6134

VI. EFFECTIVE DATE OF THIS NOTICE: *This Notice is effective October 1, 2007.*

By signing this authorization you acknowledge that you have been provided a copy of and have read and understand Covered Entity's HIPAA Privacy Notice containing a complete description of your rights and the permitted uses and disclosures, under HIPAA. While Covered Entity has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available from Covered Entity at any of its offices or by sending a written request with return address to Privacy Officer, 400 Ashville Avenue, Suite 340, Cary, NC 27518-6134
In accordance with your rights under and subject to certain restrictions imposed by HIPAA, you may inspect or copy your PHI in the designated record set maintained by Friendship Medical Center for as long as the PHI is maintained in the designated record set.

You have the right to revoke this authorization, in writing, at any time except to the extent that Friendship Medical Center has taken action in reliance on it prior to the date of revocation. A revocation is effective upon receipt by Friendship Medical Center of a written request to revoke, and a copy of the executed authorization form to be revoked at the address listed above (Privacy Officer address on page 1).

By signing this authorization you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for re-disclosure by the recipient and no longer protected under HIPAA.

Friendship Medical Center will provide the patient with a copy of this signed authorization. Acknowledged and agreed to by the following:

_____	_____	_____
Signature (patient/patient representative)	*Relationship to Patient*	*Date*
_____	_____	
Full Name (Print)	*Date of Birth*	

There are four parts of this HIPAA privacy practice that you may chose to sign:

*Part A: **read carefully**; Dr. Troy cannot treat you if you have medical insurance and do not sign this part.*

*Part B: **[optional]** consent to discuss (non-emergently) your health records with people you specify*
This is " blanket" permission to discuss all aspects of your Protected Health Information, without restriction.

*Part C: **[optional]** consent to discuss (non-emergently) **selected parts** of your health records with people you specify*
This is a permission to discuss all aspects of your Protected Health Information, except some commonly acknowledged sensitive topics.

*Part D: **[optional]** consent to discuss (non-emergently) **selected parts** of your health records with people you specify;*
This is a permission to discuss the parts of your Protected Health Information that you list, and nothing other than those items listed.

Part A: Consent for release of PHI for purposes of payment, as required by North Carolina Law

By signing below Part A, you are agreeing to permit your PHI to be released to your health insurance (or any other person or entity responsible for paying for your healthcare services) for payment purposes. Be aware that there is a clause in all of Dr. Troy's contracts with all insurance carriers that require her to both file all claims with them and to provide PHI on request. Dr. Troy cannot provide PHI selectively without jeopardizing her contracts with insurance carriers. In short, if the consent below is not signed, Dr. Troy cannot provide medical care.

_____	_____	_____
Signature (patient/patient representative)	*Relationship to Patient*	*Date*
_____	_____	
Full Name (Print)	*Date of Birth*	

Part B: Authorization to release PHI to family members, friends, caretakers YOU MAY REFUSE TO SIGN PART B

By signing below Part B, you acknowledge and agree that Friendship Medical Center may use or disclose Protected Health Information to the persons you write below. This authorization includes release of information on the use of alcohol, drugs, and tobacco; the diagnosis and treatment of HIV infection or other sexually transmitted diseases; and the diagnosis and treatment of mental illness.

By signing Part B, you agree that Friendship Medical Center or any of its Business Associates may disclose all of your personal health care information to the following person(s):

Full Name (printed)	*Date of Birth*	*Relationship*
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____	_____	_____
Signature (patient/patient representative)	*Relationship to Patient*	*Date*
_____	_____	
Full Name (Print)	*Date of Birth*	

Part C: Authorization to release PHI to family members, friends, caretakers
YOU MAY REFUSE TO SIGN PART C

By signing below Part C, you acknowledge and agree that Friendship Medical Center may use or disclose Protected Health Information to the persons you list below. This authorization excludes information on the use of alcohol, drugs, and tobacco; the diagnosis and treatment of HIV infection or other sexually transmitted diseases; and the diagnosis and treatment of mental illness.

By signing Part C, you agree that Friendship Medical Center or any of its Business Associates may disclose your personal health care information to the following person(s):

Full Name (printed) *Date of Birth* *Relationship*

***Line 1, Part C**:* _____ _____ _____

*The person listed on **Line 1, Part C** may have all information EXCEPT information about my use of*

alcohol	*diagnosis and treatment of HIV infection*
drugs	*diagnosis and treatment of sexually transmitted disease other than HIV*
tobacco	*diagnosis and treatment of mental illness*
	sexual activity and/or sexual orientation

*If the person on **Line 1, Part C** may have any of the above listed sensitive/personal information, please hand write those things on this line:* _____

_____.

_____ _____ _____

Signature (patient/patient representative) *Relationship to Patient* *Date*

_____ _____

Full Name (Print) *Date of Birth*

Full Name (printed) *Date of Birth* *Relationship*

***Line 2, Part C**:* _____ _____ _____

*The person listed on **Line 2, Part C** may have all information EXCEPT information about my use of*

alcohol	*diagnosis and treatment of HIV infection*
drugs	*diagnosis and treatment of sexually transmitted disease other than HIV*
tobacco	*diagnosis and treatment of mental illness*
	sexual activity and/or sexual orientation

*If the person on **Line 2, Part C** may have any of the above listed sensitive/personal information, please hand write those things on this line:* _____

_____.

_____ _____ _____

Signature (patient/patient representative) *Relationship to Patient* *Date*

_____ _____

Full Name (Print) *Date of Birth*

Part D: Authorization to release PHI to family members, friends, caretakers
YOU MAY REFUSE TO SIGN PART D

By signing below Part D, you acknowledge and agree that Friendship Medical Center may use or disclose Protected Health Information to the persons you list below. This authorization includes only the information you specify and nothing else.

By signing Part D, you agree that Friendship Medical Center or any of its Business Associates may disclose specific personal health care information to the following person(s):

Full Name (printed) *Date of Birth* *Relationship*

***Line 1, Part D**:* _____ _____ _____

*The person listed on **Line 1, Part D** may have only the information I have listed below:*

_____

_____

_____

_____.

_____ _____ _____

Signature (patient/patient representative) *Relationship to Patient* *Date*

_____ _____

Full Name (Print) *Date of Birth*

Full Name (printed) *Date of Birth* *Relationship*

***Line 2, Part D**:* _____ _____ _____

*The person listed on **Line 2, Part D** may have only the information I have listed below:*

_____

_____

_____

_____.

_____ _____ _____

Signature (patient/patient representative) *Relationship to Patient* *Date*

_____ _____

Full Name (Print) *Date of Birth*