



*“Accurate Diagnosis and Targeted Treatment of Pain”*

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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 GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

**If you have any questions about this notice, please contact Danny Macdougall at (865) 305-5690, 1934 Alcoa Hwy, Building D, Suite 474, Knoxville, TN, 37920.**

## **WHO WILL FOLLOW THIS NOTICE**

This notice describes the information privacy practices followed by our employees, staff and other personnel.

## **YOUR HEALTH INFORMATION**

This notice applies to the information and records we have about you, your health, health status, and the health care and services you receive from **The University Center for Pain Management of Knoxville**. Your health information may include information created and received by **The University Center for Pain Management of Knoxville**, may be in the form of written or electronic records or spoken words, and may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, related billing activity and similar types of health-related information. We are required by law to give you 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 MAY WE USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU**

We may use and disclose health information for the following purposes.

**For Treatment** – We may use health information about you to provide you with medical treatment services. We may disclose health information about you to doctors, nurses, technicians, staff or other personnel who are involved in taking care of you and your health. 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 organization may share information about you and disclose information to people who do not work for **The University Center of Pain Management of Knoxville**, in order to coordinate your care, such as phoning in prescriptions to your pharmacy, referring you out for Physical Therapy, MRI's or other referrals to physicians' offices. 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. We will request your permission before sharing health information with your family or friends unless you are unable to give permissions to such disclosures due to your health condition.

**For Payment** – We may use and disclose health information about you so that the treatment and services you receive at **The University Center for Pain Management of Knoxville** 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 you our 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 you health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will pay for the treatment

**For Health Care Operations.** - We may use and disclose health information about you in order to run **The University Center for Pain Management of Knoxville** 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.

We may also disclose your health information to health plans that provide you insurance coverage and other health care providers that care for you. Our disclosures of your health information to plans and other providers may be for the purpose of helping these plans and providers provide or improve care, reduce cost, coordinate and manage health care and services, train staff and comply with the law.

### **SPECIAL SITUATIONS**

We may use or disclose health information about you 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.

**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 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 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.

**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 judgement 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 or the hospital during treatment or while treatment is discussed.

**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. Examples of disclosures requiring your authorization include disclosures to your partner, your spouse, your children and your legal counsel.

We also will not use or disclose your health information for the following purpose without your specific, written Authorization:

**Any disclosure of your psychotherapy notes** – These are the notes that your behavioral health provider maintains that record your appointments with your provider and are not stored with your medical record.

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 an uses or disclosures already made with your permission.

**USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT**

Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person’s involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based our professional judgment.

We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

**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 keep and use to make decisions about your care. You must submit a written request to **The University Center for Pain Management of Knoxville Medical Records Associate** in order to inspect and/or copy records of 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 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. A modified request may include requesting a summary of your medical record. If you request to view a copy of your health information, we will not charge you for inspecting your health information. If you wish to inspect your health information, please submit your request to **The University Center for Pain Management of Knoxville Medical Records Associate**.

**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 the information is kept by **The University Center for Pain Management of Knoxville Medical Records**. We may deny your request for an amendment if your request is not in writing or does not include a reason to support the request. In addition, we may deny or partially deny your request if you ask us to amend information that:

- We did not create, unless the person or entity that created the information is no longer available to make the amendment

- Is not part of the health information that we keep.
- You would not be permitted to inspect and copy
- Is accurate and complete

**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 you pay for treatment, services, supplies and prescriptions “out of pocket” and you request the information not be communicated to your health plan for payment or health care operations purposes.

There may be instances where we are required to release this information if required by law.

Restriction requests must be submitted in writing to **The University Center for Pain Management of Knoxville Medical Records Associate.**

#### **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.

**Right to Paper Copy of This Notice** You have the right to paper copy of this notice.

You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. You may also find a copy of this Notice on our website at [www.ucpmk.com](http://www.ucpmk.com).

#### **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. This notice will also be available in a conspicuous location in the office.

We will inform you of any significant changes to the Notice. This may be through our website and a sign prominently posted at our location.

#### **BREACH OF HEALTH INFORMATION**

We will inform you if there is a breach of your unsecured health information.

#### **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 at:

**Office of Customer Service**  
**400 Deaderick Street, 15<sup>th</sup> Floor**  
**Nashville, TN 37243-1403**  
[DHS.CustomerService@tn.gov](mailto:DHS.CustomerService@tn.gov)  
**(615) 313-4700**

**You may also file your complaint with:**

**The University Center for Pain**  
**Management of Knoxville**  
**Danny Macdougall – Office Administrator**  
**(865) 305-5690**  
[dmacdougall@utmck.edu](mailto:dmacdougall@utmck.edu)

**Acknowledgment: Receipt of Notice of Privacy Practices**

I have received a copy of **The University Center for Pain Management of Knoxville** Notice of Privacy Practices.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Legal Guardian

\_\_\_\_\_  
Relationship to Patient

If the individual or parent/legal guardian did not sign above, staff must document when and how the Notice was given to the individual, why the acknowledgment could not be obtained, and the efforts that were made to obtain it below:

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