

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.
(Staunton-Augusta Rescue Squad, Waynesboro First Aid Crew, Highland County Rescue Squad)

If you have any questions about this notice, please contact our Privacy Officer, 50 Middlebrook Avenue, Staunton, Virginia 24401 (877-331-4261).

OUR OBLIGATIONS:

We are required by law to maintain the privacy of protected health information, give you this notice of our legal duties and privacy practices regarding health information about you and follow the terms of our notice that is currently in effect. This notice is effective September 1, 2014.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Official.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office.

SPECIAL SITUATIONS:

We may disclose Health Information when required to do so by international, federal, state or local law. When necessary to prevent a serious threat to your health and safety. To our business associates that provide us with services that require health information to provide those services. If you are an organ or tissue donor. If you are a member of the armed forces and is required by military command authorities. For work related injury or illness. For public health activities and health oversight agencies for activities authorized by law. For legally required notices of unauthorized access or disclosure of your health information. In response to a court or administrative order. To law enforcement if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency 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 a coroner or medical examiner.

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

Individuals Involved in Your Care or Payment for Your Care. 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 on our professional judgment.

Disaster Relief. 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 WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. You have the right to be notified upon a breach of any of your unsecured Protected Health Information. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You have the right to a paper copy of this notice.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office.

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 Privacy Official, Rachel Ramsbottom, PO Box 2828, Staunton, Virginia 24402 540-213-0528 or toll free at 877-331-4261. All complaints must be made in writing. **You will not be penalized for filing a complaint.** For more information on HIPAA privacy requirements, please visit www.hhs.gov/ocr/privacy/hipaa/complaints/, or call (877) 696-6775.