



## ***Notice of Health Information Practices***

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

To effectively treat you, Dialysis Clinic Inc. (DCI) must collect health information about you and disclose it to other people. Your health information is confidential and we have policies and procedures in place to protect it. This notice describes: what types of information we collect, when and to whom we may give your information, and other information. This form is not a contract which forms the basis of any private right of action.

*We reserve the right to change our health information practices; in this case we will make available a copy of the changes in the DCI facility and on the web.*

### **YOUR HEALTH INFORMATION RIGHTS:**

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

- Limit certain uses/disclosures of your health information
- Ask to correct your medical record. DCI may deny your request & a written response provided within 60 days.
- Request in writing an electronic or paper copy of your medical and billing information. DCI has up to 30 days to respond to this request unless an extension is provided and may charge a permissible fee based on state laws.
- Request in writing confidential communication by alternative means or by alternative location.
- Receive a list of when your information was shared except for about treatment, payment, and operations or when a valid authorization was provided.
- Receive a paper copy upon request of this notice.
- File a complaint if you feel your rights have been violated by contacting the U.S. Department of Health and Human Services Office for Civil Rights. The address is provided at the bottom of this notice.
- Request to restrict any uses or disclosures of information that is solely related to a health care item or service that has been paid in full, out-of-pocket, by you.
- Receive written notice in the event of a breach of your health information.
- Choose someone to act for you; a medical power of attorney or a legal guardian. That person can exercise your rights and make choices about your health information.

### **YOUR CHOICES:**

In these situations, you have the right to tell us your choices about what DCI shares.

- Share information with your family, close friends, or other involved in your care.
- Share information in a disaster relief situation.

In these situations, you have the choice to give DCI written permission to share your information.

- Marketing purposes.
- Most sharing of psychotherapy notes.

In this situation, DCI may contact you initially, but you can tell us not to contact you again.

- Fundraising efforts.

### **DCI RESPONSIBILITIES**

By law, DCI is required to:

- Keep your health information private and secure.
- Let you know promptly if a breach occurs that may have compromised the privacy or security of your health information.
- Follow the duties and privacy practices described in this notice.
- Provide a copy of this notice.
- Only use or disclose your health information with your written authorization, except as described in this notice.

### **DCI CONTACT INFORMATION**

Dialysis Clinic, Inc. – Corporate Office  
HIPAA Privacy Officer  
1633 Church St. Suite 500  
Nashville, TN 37203  
(615)327-3061

### **TYPES OF USES AND DISCLOSURES OF YOUR HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS**

DCI will use or disclose your health information without further permission from you for treatment, payment and operations purposes. The following describes examples of different ways that we will use and disclose this.

#### *Treatment Purposes*

- For use with any other clinic or health care provider that needs information in order to treat you

#### *Payment Purposes*

- Directly related to DCI being paid for its health care services. (i.e. filing an insurance claim for payment for treatments provided)
- For DCI's own payment purposes or to another clinic/health care provider for its payment purposes
- Information will never be shared with a non-health care provider for payment purposes (i.e. a creditor)

#### *Operations Purposes*

- Assess and improve quality of care of DCI patients
- Review qualifications of any health care professional who may care for you
- Train students, other health care professionals, or non-health care professionals, to improve their skills in dialysis
- Receive accreditation, certification and licensing
- Credential DCI and non-DCI staff

- Conduct medical review, legal services, auditing functions, or DCI's compliance program
- Business management, administration, planning, and development
- Resolve internal grievances
- Use your health information in a way that does not identify you
- Complete a sale, transfer, or consolidation of clinic assets with another provider

### **OTHER USES OF YOUR HEALTH INFORMATION**

*Health Information Exchange (HIE)*: To help improve your care, we participate in an electronic health information exchange or HIE with other physicians, hospitals, and health care providers. The HIE is a way for patient health information to be shared with each other for the purpose of treating patients and for certain other administrative uses permitted by law.

If you provide us authorization to use or disclose health information about you, you may later revoke that authorization in writing. If you revoke your authorization, we will no longer use or disclose health information about you for the reasons

covered by your written authorization. We are unable, however, to take back any disclosures we already have made with your permission. Also we are required to retain our records of the care that we provided to you.

### **TYPES OF ADDITIONAL USES OF YOUR HEALTH INFORMATION**

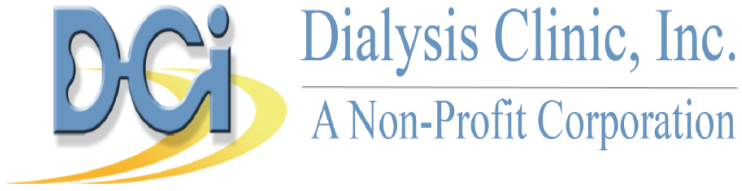
Provided are examples of additional situations DCI may release your health information without your permission:

- **Business Associates**: Services provided through contracts with business associates, such as: medical directors, accountants, and computer consultants. Information may be disclosed so they are able to perform their jobs. By contract, we require our business associates to safeguard your health information.
- **Notification of Your Location and General Condition**: In an emergency, or if you are absent or incompetent, we may need to notify a family member, personal representative, or another person responsible for your care of this information.
- **Communication with Family**: In an emergency, or if you are absent or incompetent, we may discuss your general condition/location and/or payment issues with a family member, close personal friend, or any other person you identify.
- **Research**: We provide information to persons or organizations conducting research if an Institutional Review Board (IRB) has approved their study. The IRB reviews the research study and makes rules to ensure the privacy of your health information.
- **Funeral Directors, Coroners, and Medical Examiners**: We may provide health information to these people so that they are able to carry out their duties.
- **Organ Procurement Organizations, Tissue and Eye Banks**: We may furnish health information to agencies engaged in the procurement, processing, distribution, or transplantation of organs for the purpose of donation and transplant.
- **Food and Drug Administration (FDA)**: We may provide your health information to the FDA to report adverse events regarding food supplements and/or product defects. It may also be used to report product recalls, repairs, or replacements.
- **Worker's Compensation**: Information may be provided as authorized by laws relating to worker's compensation or other similar programs.
- **Public Health**: As required by law, we may provide your health information to public health or legal authorities charged with preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, preventing or reducing a serious threat to anyone's health or safety, or death.
- **Correctional Institution**: If you are an inmate of a correctional institution, we may provide your health information to the institution or its agents.
- **Law Enforcement**: Health information may be provided as required by law, in response to a valid subpoena, or administrative request, for identification and location purposes, if you are suspected to be a victim of a crime, if you are suspected of criminal conduct on DCI premises, for special government functions such as military, national security, and presidential protective services.
- **Health Oversight Activities**: May be provided to organizations that ensure we follow health care laws and regulations.
- **Judicial and Administrative Proceedings**: May be furnished to a court order or other legal process.
- **As required by law**: When required to do so by federal, state, or local law, including the Department of Health and Human Services.

### **HOW TO REPORT A PRIVACY RIGHT VIOLATION**

If you believe your privacy rights have been violated, you may file a complaint with your clinic's Privacy Officer or with the Secretary of Health and Human Services. DCI will not retaliate against you for filing a complaint. Per 45 CFR 160.306b, complaints must be filed with the Secretary of Health and Human Services.

- File a complaint with the U.S. Department of Health and Human Services Office for Civil Rights
- By letter: 200 Independence Avenue, S.W., Washington, DC 20201
- By phone: 1-877-696-6775
- By visiting: [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/).



***Notice of Health Information Practices***

I have received a copy of the “*Notice of Health Information Practices*”. I understand that this Notice is provided to comply with federal law. It does not create any additional rights or remedies or a private cause of action.

\_\_\_\_\_  
Patient Name (printed)

\_\_\_\_\_  
Witness Name

\_\_\_\_\_  
Guardian Name, if applicable (printed)

\_\_\_\_\_  
Witness Title

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date