NOTICE OF PRIVACY POLICIES
Coastal Rheumatology Associates

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Introduction

At Coastal Rheumatology Associates, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practice describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 15, 2013 and was updated 7/2/2024, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

I,_____, understand that as part of my healthcare, Coastal Rheumatology Associates originates and maintains paper and/or electronic records describing my health history, symptom examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that the information serves as:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although, your health record is the physical property of Coastal Rheumatology Associates, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request.
- Inspect and copy your health record.
- Request that your record be amended.
- Obtain an accounting of disclosures of your health information: To do this, please contact Coastal Rheumatology Associates' Privacy Officer. This information will be provided to you within 30 days.
- Request a restriction on certain uses and disclosures of your information.
- Revoke your authorization to use or disclose your health information.
- You may request that we not submit your information to your health insurance carrier if you have paid for the service.

- You may request an electronic copy of your health record.
- Choose someone to act on your behalf.
- File a complaint if you believe your privacy rights have been violated.

Our Responsibilities

Coastal Rheumatology Associates is required to:

- Maintain the privacy and security of your health information.
- Provide you with this notice about our privacy practices.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a requested restriction and accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.
- We must promptly notify you of a breach of health information privacy or security.

We will not use or disclose your health information without your authorization, except as described in this notice. To revoke your authorization, please put your request in writing to Coastal Rheumatology Associates.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the practice's Privacy Officer at (912)349-4227.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights.

The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, D.C. 20201
Phone: 1-877-696-6775
www.hhs.gov/ocr/privacy/hipaa/complaints/

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.

For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your other physicians or a subsequent health care provider with copies of various reports that should assist him or her in treating you.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

We will use your health information for regular health operations.
For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.
Directory: Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious
affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.
Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.
Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.
Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.
Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.
Marketing: We may contact you to provide appointment reminders or information about treatment alternatives of other health-related benefits and services that may be of interest to you.
Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product to enable product recalls, repairs, or replacement.
Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.
Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability, or in a disaster relief situation.
Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.
Business Associates: We may disclose Protected Health Information to our business associates who perform functions on our behalf or provide us with services if the Protected Health Information is necessary for those functions or services.
For example: We may use another company to do our billing or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy and ensure the security of your Protected Health Information.
Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose Protected Health Information to the correctional institution or law enforcement official if the disclosure is necessary (1) for the institution to provide you with healthcare; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution. Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers the public.
Changes to the Terms of This Notice:
We may change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

I understand that as part of this organization's treatment, payment or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. I hereby acknowledge that (participating organization) will share my medical information, as permitted under federal law (H.I.P.A.A.) and Georgia and South Carolina state law, with my healthcare providers through a health information exchange. I fully understand and accept/decline the terms of this consent.

_____ _____

Patient's Signature Date