

Bellingham Family Health Clinic

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.

PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment

Your health information may be used by our physicians, providers, and staff members or disclosed to other health care professionals for the purpose of evaluating your health; diagnosing medical conditions, and providing treatment.

Payment

Your health information may be used to seek payment from your health plan, other sources of coverage such as an automobile insurer, or credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations

Your health information may be used as necessary to support the day-to-day activities and management of Bellingham Family Health Clinic's office. For example; information on the services you received may be used to support budgeting and financial reporting and activities to evaluate and promote quality to insure that our practice is meeting state and federal guidelines and laws designated to protect your health care information.

Law Enforcement

Your health information may be disclosed to law enforcement agencies, without your permission, to support government, audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting

Your health information may be disclosed to public health agencies as required by law. For example, our practice is required to report certain communicable diseases to the State of Washington Department of Health.

Other uses and disclosures require your authorization

Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Additional uses of information:

Appointment reminders

Your health information will be used by our staff to call/send you appointment reminders.

Information about treatments

Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- the right to request restrictions on the use and disclosure of your protected health information.
- the right to receive confidential communications concerning your medical condition and treatment.
- the right to inspect and copy your protected health information
- the right to request an amendment or submit corrections to your protected health information
- the right to receive an accounting of how and to whom your protected, health information has been disclosed
- the right to receive a printed copy of this notice

Privacy Statement

The clinic's duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our office.

Complaints and Contact Person

If you would like to submit a comment or complaint about our privacy practices, or obtain additional information about our privacy practices, you can do so by sending a letter outlining your concerns to the person listed below. You will not be penalized or otherwise retaliated against for filing a complaint.

Bonnie Sprague, ARNP
Bellingham Family Health Clinic
302 36th Street
Bellingham, WA 98225
360.756.9793

Effective date: This notice is effective on or after June 13, 2006

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Bellingham Family Health Clinic.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the **Notice of Privacy Practices**.

Patient or legally authorized individual signature

Date Time

Printed name if signed on behalf of the patient

Relationship
(parent, legal guardian, personal representative)

It is important to respect how you want to be notified of Lab and test results. Please check all the following which apply.

Phone messages:

- Home phone # _____ and/or Cell phone# _____
- I wish detailed messages left at this number.
- I wish only call back phone number left at this number.
- I do not want to be contacted at this number

- Work phone# _____
- I wish detailed messages left at this number.
- I wish only call back phone number left at this number.
- I do not want to be contacted at work

Mailings:

- Use my home address (Same as on registration form)
- Please write out alternative address here:

Name _____

Address _____

City/State/Zip _____

E-mail: _____ Can we send you results through
RelayHealth.com – a HIPPA compliant health information web site? Y N
Please write out how you want to be notified of lab results if it is different than above.