



Digestive Specialists, Inc.
GI Anesthesia
GI Pathology of Dayton
Springboro Imaging

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. You have the right to obtain a paper copy of this Notice upon request.

Patient Health Information

Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information. Your information may be stored electronically and if so is subject to electronic disclosure.

How We Use & Disclose Your Patient Health Information

Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.

Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment or disclose your information to payors to determine whether you are enrolled or eligible for benefits. We will submit bills and maintain records of payments from your health plan.

Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, arranging for legal services and to assess the care and outcomes of your case and others like it.

Special Uses and Disclosures

We may disclose relevant health information to a family member, friend or others involved in your care or payment for your care and disclose information to those assisting in disaster relief efforts.

Other Uses and Disclosures

We may be required or permitted to use or disclose the information even without your permission as described below:

- **Required by Law:** We may be required by law to disclose your information, such as to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
- **Research:** We may use or disclose information for approved medical research.
- **Public Health Activities:** We may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
- **Health oversight:** We may disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
- **Judicial and administrative proceedings:** We may disclose information in response to an appropriate subpoena, discovery request or court order.
- **Law enforcement purposes:** We may disclose information needed or requested by law enforcement officials or to report a crime on our premises.
- **Deaths:** We may disclose information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.
- **Serious threat to health or safety:** We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- **Military and Special Government Functions:** If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.
- **Workers Compensation:** We may release information about you for workers compensation or similar programs providing benefits for work related injuries or illness.
- **Business Associates:** We may disclose your health information to business associates (individuals or entities that perform functions on our behalf) provided they agree to safeguard the information.
- **Messages:** We may contact you to provide appointment reminders or for billing or collections and may leave messages on your answering machine, voice mail or through other methods.

In any other situation, we will ask for your written authorization before using or disclosing identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures. Subject to compliance with limited exceptions, we will not use or disclose psychotherapy notes, use or disclose your health information for marketing purposes or sell your health information, unless you have signed an authorization.

Individual Rights

You have the following rights with regard to your health information. Please contact the Contact Person listed below to obtain the appropriate form for exercising these rights.

- You may request restrictions on certain uses and disclosures. We are not required to agree to a requested restriction, except for requests to limit disclosures to your health plan for purposes of payment or health care operations when you have paid in full, out-of-pocket for the item or service covered by the request and when the use or disclosures are not required by law.
- You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.
- In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for copies. You have the right to inspect and obtain a copy of your health information, including patient medical records and billing records, but not including psychotherapy notes. *You must sign our **Authorization for Release of Medical Information** document*, which may be obtained at any of our offices. Ohio law sets limits on the amounts that we may charge for copies of medical records. Our fees are as follows (postage and summaries not included):
 - Minimum fee of \$15.00
 - \$1.00 per page for the first 10 pages
 - \$0.50 per page for pages 11-50
 - \$0.20 per page for pages 51 and higher
- You have the right to request that we amend your information.
- You may request a list of disclosures of information about you for reasons other than treatment, payment, or health care operations and except for other exceptions.
- You have the right to obtain a paper copy of the current version of this Notice upon request, even if you have previously agreed to receive it electronically.

Our Legal Duty

We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect. We are required to notify affected individuals in the event of a breach involving unsecured protected health information.

Changes in Privacy Practices

We may change this Notice at any time and make the new terms effective for all health information we hold. The effective date of this Notice is listed at the bottom of the page. If we change our Notice, we will post the new Notice in the waiting area. For more information about our privacy practices, contact the person listed below.

Complaints

If you are concerned that we have violated your privacy rights, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person

If you have any questions, requests or complaints, please contact Linda Fowler, Privacy Officer at (937) 396-2600.

Effective Date: March 26, 2013

I, _____, hereby acknowledge receipt of the Notice of Privacy Practices given to me.
(Print Name)

Signed _____, **Date** _____

If not signed, reason why acknowledgement was not obtained _____

Staff Witness seeking acknowledgement _____, **Date** _____