



NOTICE OF PRIVACY PRACTICES AT ATLANTA DERMATOLOGY AND LASER SURGERY

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

1. We Have a Legal Duty To Safeguard Your Protected Health Information (PHI)

We are legally required to protect the privacy of health information that may reveal your identity. This information is commonly referred to as “protected health information,” or “PHI” for short. It includes information that can be used to identify you that we have created or received about your past, present or future health or condition, the provision of health care to you, or the payment of this health care. We must provide you with this notice about our privacy practices that explains how, when and why we use and disclose your PHI.

With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices described in this notice.

We reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the PHI we already have. Before we make an important change to our policies, we will promptly change this notice and post a new notice. You can also request a copy of this notice at any time by calling our office.

2. How We May Use and Disclose Your PHI

We use and disclose health information for many different reasons. For some of these uses or disclosures, we need your prior consent or specific authorization. Below we describe the different categories of our uses and disclosures and give you some examples of each category.

- A. For treatment. We may use your PHI to provide you with medical treatment or services. We may disclose your PHI to doctors, physician assistants, nurses, medical assistants, medical students, and or other personnel who are involved in your medical care. Our practice will also share your PHI in order to coordinate the any and all pathology and lab work required along with necessary prescriptions.
- B. For payment. We may use and disclose your PHI so that the treatment and services you receive at our practice may be billed, and that payment may be collected from you, your insurance carrier or another third party.
- C. For health care operations. We may use and disclose your PHI for health care operations. These uses and disclosures are necessary to run our practice and to make sure all patients receive quality medical care.
- D. Treatment alternatives. We may use and disclose your PHI to tell you about or recommend possible treatment options or alternatives that may be of interest to you.
- E. Health related benefits and services. We may use and disclose your PHI to tell you about health related benefits or services that may be of interest to you.
- F. Individuals involved in your care or payment for your care. We may release your PHI to someone who is involved in your medical care. We may also give your PHI to someone who helps pay for your care. In addition we may disclose your PHI to an entity assisting in a disaster relief effort.
- G. As required by law. We will disclose your PHI when required to do so by federal, state or local law.
- H. To avert a serious threat to health or safety. We may disclose your PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure would only be to individuals knowledgeable and capable of preventing the immediate threat.

3. Other Uses and Disclosures that Do Not Require Your Consent

We may use and disclose your PHI without your consent or authorization under the following circumstances:

- A. Organ and tissue donation. If you are an organ donor, we may release your PHI to organizations that handle organ procurement or organ, eye tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- B. Military and veterans. If you are a member of the armed forces, we may release your PHI as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military personnel.
- C. Worker's compensation. If applicable, we may release your PHI for worker's compensation or similar programs. These programs provide benefits or work-related injuries or illness.
- D. Public health risks. We may disclose your PHI for public health activities. These activities generally include the following: to prevent or control disease, injury or disability, to report deaths, to report reactions to medications, to notify patients who may have been exposed to a disease or may be at risk for contracting or spreading a disease or specific condition.
- E. Health oversight activities. We may disclose your PHI to a health oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- F. Communication barriers. We may use or disclose your PHI if we are unable to obtain your consent because of substantial communication barriers, and we believe you would want us to treat you if we could communicate with you.
- G. Product monitoring and recall. We may disclose your PHI to a person or company who is required by the Food and Drug Administration to: (1) report or track product defects or problems; (2) repair, replace or recall defective or dangerous products; or (3) monitor the performance of a product after it has been approved for use by the general public.
- H. For research purposes. In most cases, we will ask for your written authorization before using your PHI for research purposes. However, in certain limited circumstances, we may use and disclose your PHI without consent or authorization if we obtain approval through a special process to ensure that such research poses little risk to your privacy. In any case, we would never allow researchers to use your name or identity publicly. We may also release your PHI without your written authorization to people who are preparing for a future research project, so long as no PHI leaves our facility.
- I. Lawsuits and disputes. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- J. Law enforcement. We may release your PHI if asked to do so by law enforcement officials, in response to a court order, subpoena, warrant, summons or similar process, in emergency circumstances to report a crime, to describe or locate a person who committed a crime.
- K. Coroners, medical examiners and funeral directors. We may release your PHI to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also release PHI about patients of our practice to funeral directors as necessary to carry out their required responsibilities and duties.
- L. National security and intelligence activities. We may release your PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

- M. Protective services for the president and others. We may disclose your PHI to authorized federal officials so they may provide protection to the President. Other authorized persons or foreign heads of state or conduct special investigations.
- N. De-identified information. We may also disclose your PHI if it has been de-identified or is otherwise made unable for anyone to connect back to you. This might occur if you are participating in a research project.
- O. Incidental disclosures. While we will take reasonable steps to safeguard the privacy of your PHI, certain disclosures may occur during or as an unavoidable result of our otherwise permissible uses or disclosures of your PHI. For example, during the course of a treatment session, other patients in the treatment area may see, or overhear discussion of, your PHI.

4. Your Rights Regarding Your PHI

You have the following rights with respect to your PHI:

- A. The right to request limits on uses and disclosures of your PHI. You have the right to ask that we limit how we use and disclose your PHI. We will consider your request, but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make.
- B. The right to choose how we send PHI to You. You have the right to ask that we send information to you to an alternate address or by alternate means. We must agree to your request so long as we can easily provide it to the location and in the format you request.
- C. The right to get a list of the disclosures we have made. You have the right to get a list of instances in which we have disclosed your PHI. The list will not include uses or disclosures that you have already been informed of, such as those made for treatment, payment or health care operations, directly to you, to your family, or in our facility directory. The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel. The list we will give you will include disclosures made in the last six years unless you request a shorter time.
- D. Right to inspect and copy. You have the right to inspect and copy medical information that may be used to make decisions about your medical care. Usually, this includes medical and billing records, but does not include psychotherapy notes. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to:

Atlanta Dermatology and Surgery, P.A.
1462 Montreal Road West, Suite 411
Tucker, Georgia 30084

- E. Right to amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the medical information. You have the right to request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to:

Atlanta Dermatology and Surgery, P.A.
1462 Montreal Road West, Suite 411
Tucker, Georgia 30084

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the PHI is (i) correct and complete, (ii) not created by us, (iii) not allowed to be disclosed, or (iv) not part of our records.

5. How to Complain About Our Privacy Practices

If you think we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed in Section 6 below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at:

US Department of HHS Government Center
John F. Kennedy Federal Building- Room 1875
Boston, Massachusetts 02203
Telephone number: 617-565-1340
Fax number: 617-565-3809
TDD: 617-565-1343

We will take no retaliatory action against you if you file a complaint about our privacy practices.

6. Person To Contact For Information About This Notice Or To Complain About Our Privacy Practices

If you have any questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact us:

Atlanta Dermatology and Surgery, P.A.
1462 Montreal Road West, Suite 411
Tucker, Georgia 30084
Telephone number: 404-296-8000
Fax number: 770-493-6842

Acknowledgement of Receipt

I am a patient of _____ [provider name]. I hereby acknowledge receipt of Atlanta Dermatology and Laser Surgery's Notice of Privacy Practices.

Name [please print]: _____

Signature: _____ Date: _____

OR

I am a parent or legal guardian of _____ [patient name]. I hereby acknowledge receipt of Atlanta Dermatology and Laser Surgery's Notice of Privacy Practices with respect to the patient.

Name [please print]: _____

Relationship to Patient: Parent Legal Guardian (Circle one)

Signature: _____ Date: _____