NORTH GEORGIA PAIN CLINIC, PC
NOTICE OF PRIVACY PRACTICES AS REQUIRED BY THE PRIVACY REGULATIONS CREATED BY HIPAA

Our practice is dedicated to maintain the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We are also required by law to provide to you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI.

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend the Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice had created or maintained in the past for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our office in a visible location at all times, and you may request a copy of our most recent Notice at any time.

We may use or disclose your IIHI in the following ways:

Treatment: Our practice
We may use your IIHI to treat you. Many of the people who work for our practice including but not limited to, our doctors and nurses, may use or disclose your IIHI in order to treat you or assist others in your treatment. We may disclose your IIHI to others who may assist in your care, such as your spouse, children, and/or parents. We may also disclose your IIHI to other health care providers for purposes related to your treatment.

Payment**:** Our practice may use and disclose your IIHI in order to bill and collect payment for services rendered. This may be released to your insurer, third parties who may be responsible for payment, or other health care providers and entities to assist in their billing and collection efforts.

Health Care Operations: We may use and disclose your IIHI in order to operate our business, conduct cost management, and business planning activities. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.

Release of Information to Family/Friends**:** Our practice may release your IIHI to a friend or family member who is involved in your care, or who assists in taking care of you. For example, a family member who calls to verify appointments or address a billing issue.

Disclosures Required By Federal, State, or Local Laws.

Use and Disclosure of your IIHI and Certain Special Circumstances:

-Serious Threats to Health and Safety **-Military/Veterans** **-Workers Compensation**
-National Security & Intelligence Activities **-Inmates & Individuals in Custody**

Public Health Risk: Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information.

Health Oversight Activities: Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. These include but are not limited to: investigations, audits, licensure, disciplinary activities, and criminal procedures, activities necessary for the government to monitor government programs, compliance with civil right laws, and the health care system in general.

Law Enforcement: We may release the IIHI if asked to do so by law enforcement officials regarding criminal conduct at our office, in response to a warrant, summons, court order, subpoena, in an emergency to report a crime, or concerning a death we believe has resulted from criminal conduct.

Prescription Medications: It is a FELONY in the State of Georgia to obtain narcotics from more than one physician at a time without making all other physicians aware. In this circumstance, we may release your IIHI to the patient's pharmacy or physician/staff involved in the patient's care in order to ascertain that this is not being done.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services: We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Business Associates: We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

All request, questions, and/or breaches should be submitted to: **HIPAA Compliance Officer C/O** ***North Georgia Pain Clinic, PC 1320 Oakside Drive Suite 203 Canton, GA 30114.*** **(770) 479-2322.**

North Georgia Pain Clinic

RECEIPT FOR NOTICE OF PRIVACY PRACTICES/
WRITTEN ACKNOWLEDGEMENT FOR HIPAA PRACTICES

I, ___________________________________, acknowledge I have been provided a copy of the ***Notice of Privacy Practices*** and that I have read (or had the opportunity to read if I so choose) and understood the Notice.

For health information disclosure:

I authorize North Georgia Pain Clinic (physicians and staff) permission to discuss and/or disclose my health information with the following person/persons listed below: I understand that my personal health information may be re-disclosed the person(s) or organizations (s) and may no longer be protected by law.

1. ___________________________________ Phone: _____________________Relationship_______________
2. ___________________________________ Phone: _____________________Relationship_______________
3. ___________________________________ Phone: ________________ _____Relationship_______________

I understand that this information **may include** any and all treatment plans, medication issues, history of acquired immunodeficiency syndrome (AIDS); sexually transmitted diseases; human immunodeficiency virus (HIV) infection; behavioral health service/psychiatric care and evaluations; treatment for alcohol and/or drug abuse; or similar conditions. You have the right to take back ("revoke") your authorization at any time, in writing, except to the extent North Georgia Pain Clinic has acted based on your permission. The following **information *should not* be released:**____.

For oral communications: Please *initial* the following:

_____ I authorize North Georgia Pain Clinic to leave information on my provided home/cell phone answering machine/voicemail.

_____ I do not authorize North Georgia Pain Clinic (physicians and staff) permission to discuss my medical treatment with any family member or friends.

_____ Patient refused to sign acknowledgement.

Patient Name: _________________________________

SSN # ____ DOB: _____________________________

Patient Signature: ______________________________ Date: _____________________________

Witness: _____________________________________ Date: _____________________________