HIPAA Omnibus Notice of Privacy Practices

**Albany ENT & Allergy** **Services, P.C.**

[123 Everett Rd Albany, NY 12205](https://www.google.com/maps/search/?api=1&query=123+Everett+Rd&query_place_id=ChIJNyrxq5IL3okRC6xy5JTKam0) Phone: [(518) 701-2085](tel:+15187012085)

**Health Insurance Portability and Accountability Act of 1996**

**HIPAA OMNIBUS** **NOTICE OF PRIVACY PRACTICES**

**Effective April 14, 2003**

**Revised: March 25, 2013**

**Privacy Officer – Tammy Otis**

[totis@albanyent.com](mailto:totis@albanyent.com)

**By signing the Acknowledgement form you are only acknowledging that you received, or have been given the opportunity to receive, a copy of our Notice of Privacy Practices.**

**This Notice of Privacy Practices is NOT an authorization.  This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your Protected Health Information (PHI) to carry out   Treatment, Payment   or   Health   Care Operations (TPO) and for other purposes that are   permitted   or   required   by   law.   It   also describes your rights to access and control your   Protected   Health   Information.   Please review it carefully.**

We reserve the right to change this notice at any time and to make the revised or changed notice effective in the future. A copy of our current notice will always be posted in the waiting area. You may also   obtain   your   own   copy   by   accessing   our website    at    <https://albanyentandallergy.com/> or calling the Privacy Officer at (518) 701-2070.

Some examples of **Protected Health Information**include information about your past,

present or future physical or mental health condition, genetic information, or information about your health care benefits   under   an   insurance   plan, each   when combined with identifying information such as your name, address, social security number or phone number.

**USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION**  
There are some situations when we do not need your written authorization before using your health information or sharing it with others, including:

**Treatment:**We   may   use   and   disclose   your Protected    Health    Information    to   provide, coordinate, or manage your health care and any related   services.   For   example, your   Protected Health Information may be provided to a physician to whom you have been referred to ensure that the physician   has   the   necessary   information   to diagnose or treat you.

**Payment:**Your Protected Health Information may be used, as needed, to obtain payment for your health care services after we have treated you.  In some cases, we may share information about you with your health insurance company to determine whether it will cover your treatment.

**Healthcare Operations:**We may use or disclose, as needed, your Protected Health Information in order   to   support   the   business   activities   of   our practice, for   example:   quality   assessment, employee   review, training   of   medical   students, licensing, fundraising, and conducting or arranging for other business activities.

**Appointment   Reminders   and   Health-related Benefits and Services:**We may use or disclose your Protected Health Information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your Protected Health Information for **fundraising activities**, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

**Friends and Family Involved in Your Care:**If you have not voiced an objection, we may share your   health   information   with   a   family   member, relative, or close friend who is involved in your care or payment for your care, including following your death.

**Business   Associate:**We   may   disclose   your health information to contractors, agents and other “business associates” who need the information to assist us with obtaining payment or carrying out our business operations. For example, a billing company, an accounting firm, or a law firm that provides professional advice to us.  Business associates are required by law to abide by the HIPAA regulations.

**Proof of Immunization:**We may disclose proof of immunization   to   a   school   about   a   student   or prospective student at the school, as required by State or other law.  Authorization (which may be oral) may be obtained from a parent, guardian, or other person acting in loco parentis, or by the adult or emancipated minor.

**Incidental    Disclosures**:   While    we    will    take reasonable steps to safeguard the privacy of your health   information, certain   disclosures   of   your health   information   may   occur   during   or   as   an unavoidable result of   our otherwise   permissible uses or disclosures of your health information.  For example, during a treatment session, other patients in the treatment area may see, or overhear discussion of, your health information.

**Emergencies or Public Need:**

We may use or disclose your health information if you   need   emergency   treatment   or   if   we   are required by law to treat you.

We  may  use  or  disclose  your  Protected  Health Information  in  the  following  situations  without  your authorization:  as  required  by  law,  public  health issues, communicable diseases, abuse, neglect or domestic  violence,  health  oversight,  lawsuits  and disputes,  law  enforcement,  to  avert  a  serious  and imminent threat to health or safety, national security and  intelligence  activities  or  protective  services, military   and   veterans,   inmates   and   correctional institutions,   workers’   compensation,   coroners, medical examiners and funeral directors, organ and tissue   donation,   and   other   required   uses   and disclosures.    We    may    release    some    health information   about   you to   your   employer   if   you employer hires us to provide you with a physical exam and we discover that you have a work-related injury or disease that your employer must know about to comply with employment laws. Under   the   law, we   must   also   disclose   your Protected Health Information when required by the Secretary of the Department of Health and Human Services   to   investigate   or   determine   our compliance with the requirements under Section 164.500.

**REQUIREMENT FOR WRITTEN AUTHORIZATION**

There are certain situations where we must obtain your written authorization before using your health information or sharing it, including:

**Most   Uses   of   Psychotherapy   Notes, when** appropriate.

**Marketing**:  We may not disclose any of     your health information for marketing purposes if our practice   will   receive   direct   or   indirect   financial payment not reasonably related to our practice’s cost of making the communication.

**Sale of Protected Health Information:**We will not sell your Protected   Health   Information   to   third parties.

**You may revoke the written authorization**, at any time, except when we have already relied upon it. To revoke a written authorization, please write to the Privacy Officer at our practice.  You may also initiate   the   transfer   of   your records   to   another person by completing a written authorization form.

**PATIENT RIGHTS**

**Right to Inspect and Copy Records.**You have the right to inspect and obtain a copy of your health information, including medical and billing records. To   inspect   or   obtain   a   copy   of   your   health information, please submit your request in writing to the practice. **We may charge a fee for the costs of copying, mailing or other supplies**. If you would like an electronic copy of your health information, we will provide one to you if we can readily produce such information in the form requested. In some   limited   circumstances, we   may deny the request. Under federal law, you may not inspect or copy  the  following  records:  Psychotherapy  notes, information compiled in  reasonable anticipation of, or used in, a civil, criminal, or administrative action or   proceeding,   protected   health   information restricted  by  law,  information  related  to  medical research  where  you  have  agreed  to  participate, information whose disclosure may result in harm or injury  to  you  or  to  another  person,  or  information that was obtained under a promise of confidentiality.

**Right to Amend Records.**If you believe that the health information, we have about you is incorrect or incomplete, you may request an amendment in writing.  If we deny your request, we will provide a written notice that explains our reasons.  You will have the right to have certain information related to your request included in your records.

**Right to an Accounting of Disclosures.**You have   a   right   to   request   an “accounting   of disclosures” every   12   months, except   for disclosures made with the patient’s or personal representatives written authorization; for purposes of treatment, payment, healthcare operations; required by law, or six (6) years prior to the date of the   request. To obtain a request   form   for   an accounting   of   disclosures, please write   to   the Privacy Officer.

**Right to Receive Notification of a Breach**. You have the right to be notified within sixty (60) days of the   discovery   of   a   breach   of   your   unsecured protected health information if there is more than a low   probability   the   information   has   been compromised.

**Right to Request Restrictions.**You have the right to request that we further restrict the way we use and disclose your health information to treat your condition, collect payment for that treatment, run our normal business operations or disclose information about you to family or friends involved in your care. Your request must state the specific restrictions requested and to whom you want the restriction to apply.  Your physician is not required to agree to your request except if you request that the   physician   not   disclose   Protected   Health Information to your health plan when you have paid in full out of pocket.

**Right to Request Confidential Communications.**You have the right to request that we contact you about your medical matters in a more confidential way, such as calling you at work instead of at home.  We will not ask you the reason for your request, and   we   will   try   to   accommodate   all reasonable requests.

**Right to Have Someone Act on Your Behalf.**You have the right to name a personal representative who may act on your behalf to control the privacy of your health information. Parents and guardians will generally have the right to control the privacy of health information about minors unless the minors are permitted by law to act on their own behalf.

**Right to Obtain a Copy of Notices.**If you are receiving this Notice electronically, you have the right to a paper copy of this Notice.

**Right to File a Complaint.**If you believe your privacy rights have been violated by us, you may file a complaint with us by calling the Privacy Officer at (518) 701-2070, or with the Secretary of the Department of Health and Human Services. We will not   withhold   treatment or act

against you for filing a complaint.

**Use and Disclosures Where Special Protections May Apply.**Some kinds of information, such as alcohol   and   substance   abuse   treatment, HIV- related, mental health, psychotherapy, and genetic information, are considered so sensitive that state or federal laws provide special protections for them. Therefore, some parts of this general Notice of Privacy Practices may not apply to these types of information.  If you have questions or concerns about the ways these types of information may be used or disclosed, please speak with your health care provider.