

Southwest Ohio Pain Management/Desert Valley Physicians

5700 Gateway Blvd., Suite 100B  
Mason, OH 45040  
(513) 229-7800 Fax (513) 229-7888

For the remainder of this action manual, the above practice name will be called "Clinic".

This notice describes how your private health information at the Clinic may be used or disclosed.  
Review this information carefully.

Clinic is required by law, to maintain the privacy and confidentiality of your protected health information and to provide you, our patient, with a notice of our legal duties and privacy practices with respect to your protected health information.

Clinic notice of privacy agreement definitions:

Patient, you or your shall mean the same as the person named below:

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(Patient Name)

Clinic shall mean the same as the above clinic's name.

Privacy rule shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E of the 1996 HIPPA.

Clinic notice of privacy agreement shall mean the same as Agreement meaning this specific agreement.

Notice shall mean the same as Clinic notice of privacy agreement also meaning this specific agreement.

Disclosure of your protected Health Care Information:

Treatment Records:

1. Your private health information may be used in the Clinic by all Clinic doctors for the purpose of treating you on a day-to-day basis.
2. If we need to refer you to another doctor outside the Clinic it may be necessary to provide them with your protected health information.
3. From time to time a substitute doctor of the Clinic's choosing may treat you. In those instances your protected health information would be shared with that doctor without advance permission or notice. This could happen if your treating doctor is sick, or unavailable, or on vacation, or other emergencies.

Patient Payment Records:

1. In order to get your bill paid, we will disclose your private health information as is required by your insurance companies to get your bill paid at the clinic. Included in this information will be a diagnosis of your condition, treatment dates, injury or health condition dates of onset, and specific billing codes that describe the type of care you received at this Clinic.
2. If you are a Worker's Compensation patient by law the Clinic must disclose any of your private health information.

Emergencies:

In the event there is an emergency that involves you, the clinic may disclose your private Health Information to a Family member or your legal guardian. This may include your medical emergency condition or death

Public Health Officials:

The law requires that the Clinic must disclose your protected Health information to public officials in the following situations:

1. In the prevention or controlling communicable diseases.
2. Reporting suspected domestic violence or child abuse and neglect.
3. Reaction to prescribed drugs to the food and drug administration.
4. Judicial proceedings; judges.
5. Law enforcement agencies that deal with locating fugitives, witnesses or missing persons. Complying with a court order or a subpoena.
6. Coroners or medical examiners.
7. Organization involved in getting or banking transplant organs, if you die.

8. Research required by law to report in association with the Institutional Review Board.
9. Public Safety Officials, in instances where the public health or safety may be jeopardized.
10. Special government agencies such as the military, national security or prison authorities.
11. Clinic sale, if the practice is sold to another doctor your private information becomes the property and the responsibility of the new owner.

Your rights as described in the HIPPA Act:

You have the right to put certain restrictions on how the Clinic uses and discloses your private health information. The Clinic does not have to agree to the restriction in certain situations.

You have the right to have the Clinic send all mail to you at a different address than where you live. You must request this.

You have the right to look at all your health information files that the Clinic has.

You have the right to get a copy of any of your health information.

You have the right to request a change in any of the chart notes or information in your health information files. The Clinic can by law not comply with your requested change to health information. The Clinic however, must give you a written response as to why it does not want to change your health information record. Also the Clinic will tell you how you can disagree with the denial.

You have the right to have the Clinic show you all the people or places that your protected health information has been sent to.

You have the right to have a copy made of this Notice of Privacy Practices at anytime you ask for it.

Further changes to this notice of privacy agreement:

Clinic can change this notice at any time. This notice will continue to be in force until new changes have been made. Any time changes are made to this notice, Clinic is required by law to have you sign a new copy and then give you a copy.

If you have any questions about this notice or any questions about your protected health information, please discuss this with the clinic's security officer. Feel free to call our clinic at the number mentioned at the top of this agreement and make an appointment to discuss this notice. We will make an appointment for you for a personal phone call or in person conference within two working days.

Complaints about the Clinic's privacy policies or procedures:

Any complaint about how the clinic has handled your private health information should be directed to the clinic's Privacy officer. You can call the Clinic at the above phone number and the Clinic will make an appointment with you to discuss your concerns within two working days. If you are not satisfied with how the clinic handles your complaint you can send a formal complaint to:

Office for Civil Rights  
U.S. Department of Health & Human Services  
50 United Nations Plaza – Room 322  
San Francisco, CA 94102

Restrictions or changes of your private health information or changes of mailing address or phone number, fax number, or e-mail. If you wish to:

- Request for a restriction of your protected health information
- Change where the clinic sends your mail
- Change where the clinic communicates to you by phone, fax, or e-mail
- Wish to object about the Notice of Privacy Agreement

Simply ask any of our clinic employees for the form to do so.

Retention and storage of treatment records:

By law the Clinic is required to retain any original copies of medical records of adults for at least six years after the last date an adult patient receives medical or healthcare services and if the patient is a child the Clinic must retain records for at least three years after the child's eighteenth birthday or six years after the last date the child receives services, whichever occurs later.

Records may be destroyed, after the appropriate time has passed, without any treatment activity.

All records are maintained at the Clinic located at 5700 Gateway Blvd., Suite 100B, Mason, OH 45040.

All requests for copies of treatment records should be directed to this office.

In the event the Clinic is sold; original treatment records will remain with the practice. Patient will be notified of the ownership change and directed as to how they can request copies of their treatment.

In the event the clinic is closed; records will be moved to a secure storage facility. Patients will be notified and directed as to how they can request copies of their treatment records.

As required by the privacy regulations, I hereby that this is the most current copy of the Clinics "Notice of Privacy Agreement" with the current revision Date of December, 2008.

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide the Clinic with my authorization and consent to use and disclose my protected Health Care Information for the purpose of treatment, payment, and health care operations as described in the Privacy Notice.

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Patient's Name (print)

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Patient's Signature

Date

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Authorized Facility Signature

Date

I have read the Privacy Notice and understand my rights contained in this notice. However I do not agree to the above notice. Therefore I will not sign above. My signature below this line indicates that I do not agree to this notice, however I have received a copy of this notice as required by law.

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Patient's Name (print)

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Patient's Signature

Date

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Authorized Facility Signature

Date

\*Keep a copy in patient's file