

## **Privacy Notice**

**THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU, WHICH IS PROTECTED UNDER THE HIPAA PRIVACY RULE MAY BE USED AND DISCLOSED AND HOW YOU CAN HAVE ACCESS TO THIS INFORMATION.**

**THE EFFECTIVE DATE OF THIS NOTICE IS \_\_September 23, 2013\_\_**

PLEASE REVIEW THE FORM CAREFULLY. THIS NOTICE GIVES YOU INFORMATION REQUIRED BY LAW about the duties and privacy practices of BEHL ORTHODONTICS, PLLC.

To protect the privacy of your medical information. We provide benefits to you as described in your benefits literature. As a result of offering benefits, we are required to follow the terms of this notice until it is replaced. We reserve the right to change the terms of this notice at any time. If we make changes to this notice, we will revise it and send a new notice to all covered persons at that time. We reserve the right to make any changes apply to all your protected health information maintained before and after the effective date of the new notice.

### **Purposes for which We May Use or Disclose Your Protected Health Information Without Your Consent or Authorization**

We may use and disclose your protected health information for the following purposes:

*Treatment.* For example, we may disclose your protected health information to determine if a medical condition is pre-existing or for the pre-certification of care.

*Payment.* For example, we may use or disclose your protected health information to business associates or insurance carriers for the payment of claims or to provide eligibility information to your doctor when you receive treatment.

*Health Care Operations.* For example, we may use or disclose your medical information (i) for underwriting, premium rating, or other activities relating to the creation, renewal or replacement of a contract of health insurance, (ii) to authorize business associates to perform data aggregation services (iii) to perform normal employee benefits operations.

*As Required By Law.* For example, we must allow the U.S. Department of Health and Human Services to audit Plan records. We may also disclose your medical information as authorized by and to the extent necessary to comply with workers' compensation or other similar laws.

*To Business Associates.* We may disclose your medical information to business associates we hire to assist us. Each business associate must agree in writing to ensure the continuing confidentiality and security of your medical information.

*Sale of Business.* In the event that the company is sold or merged with another organization, your protected health information will become the property of the new owner.

**We may also use and disclose your medical information as follows:**

- To comply with legal proceedings, such as a court or administrative order or subpoena.
- To law enforcement officials for limited law enforcement purposes.
- To a family member, friend or other person, for the purpose of helping you with your health care or with payment for your health care, if you are in a situation such as a medical emergency and you cannot give us your agreement.
- To your personal representatives appointed by you or designated by applicable law.
- For research purposes in limited circumstances.
- To a coroner, medical examiner, or funeral director about a deceased person.
- To an organ procurement organization in limited circumstances.
- To avert a serious threat to your health or safety or the health or safety of others.
- To a governmental agency authorized to oversee the health care system or government programs.
- To federal officials for lawful intelligence, counterintelligence and other national security purposes.
- To public health authorities for public health purposes.
- To appropriate military authorities, if you are a member of the armed forces.

**Uses and Disclosure Requiring Your Authorization**

Certain uses and disclosures require your specific authorization to include if applicable, most uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and any sale of PHI. Sale of PHI refers to any direct or indirect remuneration tied to disclosure of PHI with certain exceptions such as for public health purposes, purposes for treatment or payment, research with reasonable cost-based fee, disclosure to business associate to perform services, if only remuneration is for the services, individual requested disclosures, or disclosures required by law.

**Uses and Disclosures with Your Permission**

We will not use or disclose your medical information for any other purposes unless you give your written authorization to do so. Genetic information is not permitted to be used or disclosed for underwriting purposes (if applicable). Genetic information includes genetic tests and manifested diseases or disorders of you and your family members. If you give written authorization to use or disclose your medical information for a purpose that is not described in this notice, then, in most cases, you may revoke it in writing at any time. Your revocation will be effective for all your medical information we maintain, unless we have taken action in reliance on your authorization.

## **Your Rights**

You may make a written request to do one or more of the following concerning your protected health information that we maintain:

To put additional restrictions on the use and disclosure of your medical information. We do not have to agree to your request.

To obtain an electronic copy of PHI. The electronic copy may be provided in the form and format requested by you or if not readily available, then you may receive electronic PHI in a mutually agreeable machine readable format such as MS Word, Excel, PDF or HTML. In limited cases, we do not have to agree to your request.

To be notified of a breach of unsecured PHI.

To communicate with you in confidence about your medical information by a different means or at a different location than we are currently doing. We do not have to agree to your request unless such confidential communications are necessary to avoid endangering you. Your request must specify the alternative means or location to communicate with you in confidence.

To see and get copies of your protected health information. In limited cases, we do not have to agree to your request.

To correct your medical information. In some cases, we do not have to agree to your request.

To receive a list of disclosures of your protected health information that we and our business associates made for certain purposes for the last 6 years (but not for disclosures before the date your coverage began).

To send you a paper copy of this notice if you received this notice by e-mail or on the internet.

If you want to exercise any of these rights described in this notice, please contact the Contact Office (below). We will give you the necessary information and forms for you to complete and return to the Contact Office.

## **Complaints**

If you believe your privacy rights have been violated, you have the right to complain to us or to the Secretary of the U.S. Department of Health and Human Services. You may file a complaint with us at our Contact Office (below). We will not retaliate against you if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

## **Contact**

To request additional copies of this notice or to receive more information about our privacy practices or your rights, please contact us as indicated below:

Contact Officer: Kristen Anderson

BEHL ORTHODONTICS, PLLC.

Telephone: (757) 224-3004 Fax: (757) 351-3550

Email: [kristen@behlorthodontics.com](mailto:kristen@behlorthodontics.com)

Address: 142 Independence Blvd, Virginia Beach, VA 23462