

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Uses and disclosures of health information

We seek your consent to use health information about you for treatment, to obtain payment for treatment, for administrative purposes and to evaluate the quality of care that you receive. You can revoke your consent at any time.

Following are examples of the types of uses and disclosures of your protected health information that the physician practice is permitted to make once you have signed a consent form. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our practice once you have provided consent.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party (for example, a home health agency that provides care to you), other physicians who may be treating you (for example, a referral physician that needs certain information to diagnose or treat you), or another healthcare provider who at the request of your physician becomes involved in your care (for example, a specialist or a laboratory). In all cases, only the necessary or relevant information will be used and disclosed and proper permission will be obtained before any information is released.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan undertake before it approves or pays for the health care services we recommend. These activities include, but are not limited to, making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity and undertaking utilization review activities (for example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission).

Administrative Purposes: We may use or disclose your protected health information in order to support the business activities the practice. These activities include, but are not limited to, quality assessment activities and patient satisfaction surveys, employee review activities, training of medical students, licensing, marketing activities and conducting or arranging for other business activities.

In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment or notify you of test results.

We will share your protected health information with third party "business associates" that perform various activities such as billing and transcription services. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

Other required uses and disclosures of health information

We may use or disclose identifiable health information about you without your authorization for several reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. We may disclose your health information to a member of your family or any other person you identify that directly relates to the involvement in your health care, or to someone who pays for your care.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual rights

In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions about you. Under federal law you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding and health information that is subject to law. Requests to access information can be made verbally or in writing and will be fulfilled in 30 days if the record is on-site, or 60 days if the record is maintained off-site.

You also have the right to receive a list of disclosures or a list of instances where we have disclosed health information about you for reasons other than treatment, payment or related administrative purposes. Requests must be made in writing, signed by you or a patient representative and include the address of where you want us to send the list of disclosures and the period of time you wish to see disclosures. We have 60 days to fulfill your request.

You have the right to ask us not to disclose any part of your protected health information for treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or other persons who may be involved in your care. Your request must state the specific restriction requested and to whom you want the restriction to apply. There is a form available for this purpose. We are not required to agree with your request. You have the right to terminate, in writing, any agreed-to restriction. For more information about your rights and the steps you can take to restrict your health information contact the person listed at the end of this notice.

If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. We may deny the request if we were not the originators of the information or if we believe the information in the record is accurate. There is a form available for this purpose. For more information about your rights and the steps that you can take to access, change or restrict your health information contact the person listed at the end of this notice. We have 30 days to respond to your request.

Finally, you have the right to request an alternative means of communication. We will not request an explanation from you as to the basis for the request. For more information on how to make a request for alternate communication means, please contact the person listed at the end of this notice.

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. Complaints will be received either verbally or in writing. There is a form available for filing a complaint. If requested, you will be notified of the resolution of your concern or complaint.

You also may send a written complaint to the Secretary of the U.S. Department of Health and Human Services. Complaints must be made in writing and must be filed within 180 days of when the act occurred. The person listed below can provide you with the appropriate address upon request.

We will not retaliate against you for filing a complaint.

Our legal duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area and in each examination room. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

If you have any questions or complaints, please contact:

Angie Long
Business Office Supervisor
(864) 224-1055
AnMed Health Campus
2000 E. Greenville Street, Suite 3000
Anderson, SC 29621

Lynn Gregory
Director, Physician Network Services
(864) 261-1699
109 Essex Drive
Anderson, SC 29621

EDWARD E. LANCASTER, III, D.M.D.
Family Dentistry
312 Williams St.
Williamston, SC 29697
(864) 847-4545

Notice of Privacy Practices

Patient Acknowledgement

Patient Name _____ **Date of Birth:**_____

I have received this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature:_____ **Date:**_____

Relationship to patient: _____
If signed by a personal representative of patient