SURGICAL ASSOCIATES OF FREDERICKSBURG, Ltd.

4548 Empire Court, Fredericksburg, VA 22408

NOTICE OF INFORMATION PRACTICES

1. This notice describes how Personal Health Information (PHI) about you may be used and disclosed and how you can gain access to this Information. Please review it carefully.

2. Surgical Associates is required by law to maintain the privacy of PHI, to provide individuals with notice of its legal duties and privacy practices with respect to PHI, and to notify affected individuals following a breach of unsecured protected health information.

3. Surgical Associates of Fredericksburg may use and disclose protected health information for treatment, payment and healthcare operations, including appointment reminders. Examples of these include, but are not limited to, requested preschool, or sports physicals, referral to nursing homes, foster care homes, home health agencies and/or referral to other providers for treatment. Payment examples include, but are not limited to, insurance companies for claims including coordination of benefits with other insurers or collection agencies. Healthcare operations include, but are not limited to, internal quality control and assurance including auditing of records and providing records to business associates, i.e. internal ancillary services.

4. Although Surgical Associates will not sell or disclose PHI for marketing, fundraising, or other purposes, we are required to notify you that your authorization would be required for us to do so.

5. Surgical Associates of Fredericksburg is permitted or required to use or disclose protected health information without the individual's written consent or authorization in certain circumstances. Two examples of such are for public health requirements or court orders.

6. Surgical Associates of Fredericksburg will not make any other use or disclosure of a patient's protected health information without the individual's written authorization. Such authorization may be revoked at any time. Revocation must be written and submitted to address of record on this form.

7. Surgical Associates of Fredericksburg will abide by the terms of this notice currently in effect at the time of the disclosure.

8. Surgical Associates of Fredericksburg reserves the right to change the terms of its notice and to make new notice provisions effective for all protected health information that it maintains. Surgical Associates of Fredericksburg will provide each patient with a copy of any revisions of its Notice of Information Practices at the time of their next visit, or at their last known address if there is a need to use or disclose any protected health information of the patient. Copies may also be obtained at any time at our offices.

9. You have the right to restrict disclosures of PHI to your health plan if you pay out of pocket in full for services rendered.

10. Any patient, guardian or personal representative has the right to inspect and obtain copies of their medical record.

11. Any patient, guardian or personal representative has the right to request amendments be made to their medical record.

12. Any patient, guardian or personal representative has the right to request a six-year accounting of all disclosures of their medical record. The history will be provided within 60 days of the request and a reasonable charge may be assessed for any copies after the first requested in a 12-month period.

13. Any patient, guardian, or personal representative has the right to request restrictions as to how their health information may be used or disclosed to carry out treatment, payment or healthcare operations. The Practice is not required to agree to the restrictions requested, but if the Practice does agree, the Practice must abide by those restrictions.

14. Any person/patient may file a complaint to the Practice and to the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with the practice, please contact the Privacy Officer at the following address and/or phone number: Surgical Associates of Fredericksburg, 4548 Empire Court, Fredericksburg, VA 22408, For inquiries or additional information, contact Administrator/Privacy Officer: Telephone 540-373-2244 Fax 540-371-4849. All complaints will be addressed and the results will be reported to the Privacy Officer.

15. It is the policy of Surgical Associates of Fredericksburg that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance of the privacy standards.

16. Surgical Associates of Fredericksburg may call the patient's home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out healthcare operations, such as appointment reminders, insurance items and any call pertaining to the patient's clinical care, including laboratory results among others.

17. Surgical Associates of Fredericksburg may mail to the home or other designated location any items that assist with carrying out the patient's treatment plan, such as appointment reminders and other material.

18. Surgical Associates of Fredericksburg will accept revocations of the Authorization to disclose Protected Health Information by certified mail only. This revocation must be sent to the attention of the Privacy Officer, Surgical Associates of Fredericksburg, 4548 Empire Court, Fredericksburg, VA 22408.

19. The signature of patient or guardian on this privacy form authorizes Surgical Associates of Fredericksburg to release Personal Health Information on the respective patient via all FMLA documents, documents provided by the patient's employer, or documents submitted by disability or insurance carrier on behalf of the patient.

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4548 Empire Court
Fredericksburg, VA 22408
(540) 373-2244 FAX (540) 371-4849

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and subsequent changes and modifications, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and care among multiple providers
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications
- Provide information to referring physicians or other medical professionals providing treatment

I have received and reviewed Surgical Associates of Fredericksburg's NOTICE OF INFORMATION PRACTICES (reverse side, Page 1 of this form) which contains a more complete description of the uses and disclosures of my health information. I understand that Surgical Associates of Fredericksburg has the right to change its NOTICE OF INFORMATION PRACTICES from time to time and that I may contact them at any time to obtain a current copy.

I understand that I have the right to revoke this authorization in the future. In order to be effective, the request must be in writing and will take effect when both the patient and the practice have signed the revocation. The revocation must include the patient's name, address, phone number, patient signature, date the revocation submitted, and reason for the request.

This authorization permits Surgical Associates of Fredericksburg to discuss my Personal Health Information (PHI) to **ONLY** those individuals I have listed below (SAF **cannot** discuss your PHI with anyone not listed below):

☐ Spouse _____ ☐ Mother _____

☐ Father _____ ☐ Adult Children _____

☐ Other_____ ☐ Other_____

I may elect to have this authorization expire on a date I specify in the future. The date I have entered below represents the date I wish this authorization to expire:

□ Check box to the left if you do not wish this authorization to expire; however, I may notify the practice in writing at a future time with an expiration date.

DATE OF AUTHORIZATION EXPIRATION: _____/_____ / _____

I fully understand and accept the terms of this authorization. I understand when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information.

NAME (print):_____ DOB: ____/____/_____ DATE:_____

SIGNATURE OF PATIENT OR GUARDIAN: _____

OFFICE USE ONLY

Date Received: _____ By: _____

□ Patient declined to sign the Authorization Form for the following reason: ***rev 1.3 9/11/2013***