



NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective Date: April 14, 2003

Dear Patient,

We understand that information about you and your health is personal. We are committed to protecting your health information. We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. If applicable law prohibits or materially limits our uses and disclosures of your health information as set forth below, we will restrict our uses or disclosures of your health information in accordance with the more stringent standard. We must follow the privacy practices described in this Notice while it is in effect.

We may change our privacy practices and the terms of this Notice at any time, if such changes are permitted by law. If we change the terms of this Notice, those changes will apply to all health information that we already hold, as well as to new information we create or receive after the changes. Before we make significant changes in our privacy practices, we will change this Notice and post it in our office. You may request a copy of our current Notice at any time.

Use and Disclose Your Health Information

We have described below the different ways we use and disclose health information:

Treatment. We may use and disclose your health information to provide, coordinate, or manage your health care and any related services. For example, we may disclose your health information to a pharmacy to fill a prescription or to a laboratory to order a blood test. We may also disclose your health information to other physicians who may be treating you or who have consulted us about your medical care.

Payment. Your health information will be used, as needed, to obtain payment for the medical treatment and services that we provide to you. For example, we may disclose your health information to your health insurance company to determine whether you are eligible for benefits or whether a particular service is covered under your health plan.

Health Care Operations. We may use or disclose your health information for our own health care operations to run our practice and to help us provide quality care to all our patients. For example, we may use your health information to review our treatment and services and to evaluate the performance of our staff in caring for you.

Business Associates. We are permitted by law to use other persons or entities as "Business Associates" to carry out treatment, payment or health care operations that may involve the use and disclosure of your health information. For example, we may use a billing service or accounting service to handle some billing and payment functions or may consult with our legal counsel on matters affecting our practice.

Appointment Reminders, Treatment Alternatives, and Health-Related Benefits. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. We may disclose health information about you to a family member or friend who is involved in your medical care. We may also give

information to someone who is involved in paying for your medical care. We may also disclose your location, condition or death in efforts to locate or notify family members or friends involved in your care. *As further described below, you may object to these disclosures by asking our office staff to assist you in filling out a request form or by contacting our Privacy Officer directly.*

Other Uses and Disclosures

Federal privacy rules allow us to use or disclose your health information without your permission or authorization for a number of other reasons, including the following:

When Legally Required. We will disclose your health information when we are required to do so by any federal, state, or local law.

For Public Health Activities. We may disclose your health information for public activities and purposes such as:

- to prevent, control, or report disease, injury, or disability as permitted by law;
- to report vital events such as birth or death as permitted or required by law;
- to conduct public health surveillance, investigations, and interventions as permitted or required by law;
- to collect or report adverse events and product defects, track FDA-regulated products, enable product recalls, repairs or replacements to the FDA, and to conduct post-marketing surveillance;
- to notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease, as authorized by law; or
- to report to an employer information about an individual who is a member of the workforce as legally permitted or required.

To Report Suspected Abuse, Neglect, or Domestic Violence. We may notify government authorities if we believe that a patient is the victim of abuse, neglect, or domestic violence.

To Conduct Health Oversight Activities. We may disclose your health information to a health oversight agency for activities including audits; civil, administrative, or criminal investigations, proceedings, or actions; inspections; licensure or disciplinary actions; or other activities necessary for appropriate oversight as authorized by law.

In Connection With Judicial and Administrative Proceedings. We may disclose your health information in the course of any judicial or administrative proceedings in response to a court order. In certain circumstances, we may disclose your health information in response to a subpoena to the extent authorized by state law if we receive satisfactory assurances that you have been notified of the request or that an effort was made to secure a protective order.

For Law Enforcement Purposes. We may disclose your health information to a law enforcement official for law enforcement purposes such as:

- for reporting of certain types of wounds or other physical injuries;
- pursuant to court order, court-ordered warrant, subpoena, summons, or similar process;
- for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person;
- under certain limited circumstances, when you are the victim of a crime;
- to a law enforcement official if we suspect that your health condition was the result of criminal conduct; or
- in an emergency to report a crime.

To Coroners and Funeral Directors. We may disclose your health information to a coroner or medical examiner for identification purposes, to determine cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out his duties. We may disclose such information in reasonable anticipation of death.

Organ Donation. We may disclose your health information for cadaver, organ, eye, or tissue donation purposes.

For Research Purposes. We may use or disclose your health information for research when the use or disclosure for research has been approved by an institutional review board that has reviewed the research proposal and research protocols to address the privacy of your health information.

In the Event of a Serious Threat to Health or Safety. We may, consistent with applicable law and ethical standards of conduct, use or disclose your health information if we believe, in good faith, that such use or disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

For Specified Government Functions. In certain circumstances, federal regulations authorize us to use or disclose your health information to facilitate specified government functions relating to military and veterans activities, national security and intelligence activities, protective services for the President and others, medical suitability determinations, correctional institutions, and law enforcement custodial situations.

For Workers' Compensation. We may release your health information to comply with workers' compensation laws or similar programs.

Uses and Disclosures Which You Authorize

In other situations not covered by this Notice, we will not disclose your health information other than with your written authorization. If you choose to authorize a use or disclosure, you may later revoke your authorization in writing at any time except to the extent that we have taken action in reliance upon the authorization.

Patient Rights

We have described below the rights you have with respect to your health information. In most cases, we require that you exercise those rights by asking our office staff to assist you in filling out one of our request forms or submitting your written requests to our Privacy Officer whose contact information is listed on the last page of this Notice. If requested, our office staff will assist you in making your written request on forms we will provide and in making sure that the Privacy Officer receives your request.

The right to inspect and copy your health information. In most cases, you may look at or get a copy of your health information that our staff uses for making decisions about your medical care. To look at or get a copy of your health information, you must submit a written request. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing, or other costs incurred by us in complying with your request.

If we deny your request to look at or copy your health information, we will explain why we denied your request. Depending on the circumstances, you may have the right to have a decision to deny access reviewed.

The right to request a restriction on uses and disclosures of your health information. You may ask us not to use or disclose certain parts of your health information for the purposes of treatment, payment, or health care operations. You may also request that we not disclose your health information to family members or friends who may be involved in your care. Your request must be made in writing and state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to a restriction that you may request. We will notify you if we deny your request to a restriction. If we agree to the requested restriction, we may not use or disclose your health information in violation of that restriction unless it is needed to provide emergency treatment. Under certain circumstances, we may terminate our agreement to a restriction.

The right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to request that we communicate with you in a confidential manner, such as sending mail to an address other than your home. Your request must be made in writing and state the specific manner or location for us to use to communicate with you. We will accommodate reasonable requests. We may condition this accommodation by asking you for information as to how payment will be handled or for an alternative address or other method of contact. We will not require you to provide an explanation for your request.

The right to request amendments to your health information. You may request an amendment of your health information for as long as we maintain this information. Your request must be made in writing and state a reason to support the requested amendments. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare, and provide you a copy of, a rebuttal to your statement.

The right to receive an accounting. You have the right to request an accounting of certain disclosures of your health information for purposes *other than* treatment, payment, or health care operations as described in this Notice. We are also not required to account for disclosures that you requested,

disclosures that you agreed to by signing an authorization form, disclosures to friends or family members involved in your care, or certain other disclosures we are permitted to make without your authorization. The request for an accounting must be made in writing and specify the time period sought for the accounting and the location(s) at which we have provided services on your behalf. We are not required to provide an accounting for disclosures that take place prior to April 14, 2003. Accounting requests may not be made for periods of time in excess of six (6) years. We will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee.

The right to obtain a paper copy of this Notice. Upon request, we will provide a separate paper copy of this Notice even if you have already received a copy of this Notice or have agreed to accept this Notice electronically.

Questions and Complaints

If you want more information about our privacy practices, have questions or concerns, or desire to exercise any of the above rights, please ask our office staff to assist you in filling out one of our request forms OR submit your written requests directly to our Privacy Officer at the address below. You have the right to complain to us and to the Secretary of Health and Human Services if you believe that your privacy rights have been violated or if you disagree with our privacy practices or a decision we have made about a request you have made. You may complain to us by contacting our Privacy Officer at the location listed below. You may also call our 24-hour Hotline, at 1-888-315-2362. You may also complain to the U.S. Department of Health and Human Services, Office for Civil Rights.

We encourage you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

Privacy Officer: Privacy Officer, 265 Brookview Centre Way, Suite 400, Knoxville, TN. 37919

Telephone: 865 693 1000, ext 5400 Fax: 865 293-5494 E-Mail: privacyofficer@teamhealth.com



Acknowledgment of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have received a copy of the **NOTICE OF PRIVACY PRACTICES** of _____ (“Provider”). I understand that signing this acknowledgement is not a requirement to receive treatment by Provider.

Printed Name of Patient or Personal Representative

Signature of Patient or Personal Representative

Date

If you have signed this document as the patient’s personal representative, please indicate your relationship to the patient and your authority to act for the patient:

FOR PROVIDER USE ONLY
GOOD FAITH EFFORT FORM

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- _____
- Individual refused to sign.
 - Communication barriers prohibited obtaining the acknowledgement.
 - An emergency situation prohibited obtaining the acknowledgement.
 - Other (Please specify).

Authorization for Use and/or Disclosure Of
Protected Health Information

I authorize _____ (“Provider”), its physicians and/or administrative and clinical staff to use and/or disclose the protected health information of _____ (DOB: _____) as follows:
[Name of Patient]

Name and contact information of the person/entity receiving the patient’s health information:

Specific description of the protected health information being used or disclosed to the above recipient (including relevant dates of service, type of service, origin of information and level of detail to be released):

This protected health information is being used or disclosed for the following purposes (*List specific purposes. “At the request of the individual” is acceptable if the request is made by the patient or the patient’s personal representative, and the patient or the personal representative does not state a specific purpose*):

This authorization shall be effective until ____/____/____ (DD/MM/YY) or until the happening of the following event: _____, at which time this authorization expires.

I understand that, as set forth in the Provider’s Notice of Privacy Practices, I have the right to revoke this authorization at any time by delivering written notification to the office staff at this facility or by sending written notification to:

Team Health, Inc.
265 Brookview Centre Way, Suite 400
Knoxville, Tennessee 37919
ATTN: Privacy Officer

I understand that my revocation will only be effective from the date it is received and will not be effective to the extent Provider has already relied on my authorization to use or disclose my protected health information.

I understand that my protected health information used or disclosed pursuant to this authorization may be further disclosed by the recipient and may no longer be protected by federal or state law.

I understand that Provider will not condition my treatment, payment, enrollment or eligibility for benefits (as applicable) on whether I sign this authorization, unless Provider is providing health care services to me for the purpose of creating protected health information for disclosure to a third party.

Signature of Patient or Personal Representative

Signature of Witness

Printed Name of Patient or Personal Representative

Printed Name of Witness

Date

Date

If you have signed this document as the patient’s personal representative, please indicate your relationship to the patient and your authority to act for the patient