

## 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.

This Notice of Privacy Practices (the “Notice”) tells you about the ways we may use and disclose your protected health information (“medical information”) and your rights and our obligations regarding the use and disclosure of your medical information. This Notice applies to People-Centered Health, PLLC, including its clinicians and employees (the “Practice”).

### I. OUR OBLIGATIONS.

We are required by law to:

- Maintain the privacy of your medical information, to the extent required by state and federal law;
- Give you this Notice explaining our legal duties and privacy practices with respect to medical information about you;
- Notify affected individuals following a breach of unsecured medical information under federal law;
- Follow the terms of the version of this Notice that is currently in effect; and
- Not engage in any actions that could constitute “information blocking” under the 21st Century Cures Act and the regulations promulgated thereunder.

### II. HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

- **For Treatment.** We may use and disclose medical information about you to provide you with health care treatment and related services, including coordinating and managing your health care. We may disclose medical information about you to physicians, nurses, other clinicians, and personnel who are providing or involved in providing health care to you (both within and outside of the Practice).
- **For Payment.** We may use and disclose medical information about you so that we may bill and collect from you or a third party for the health care services we provide.
- **For Health Care Operations.** We may use and disclose medical information about you for our health care operations. These uses and disclosures are necessary to operate and manage our practice and to promote quality care.
- **Appointment Reminders and Health Related Benefits and Services.** We may use and disclose medical information, in order to contact you (including, for example, contacting you by phone and leaving a message on an answering machine) to provide appointment reminders and other information.
- **Individuals Involved in Your Care.** We may disclose medical information about you to a friend or family member who is involved in your health care, but we will do so only as allowed by state or federal law (with an opportunity for you to agree or object when required under the law), or in accordance with your prior authorization.

- **As Required by Law.** We will disclose medical information about you when required to do so by federal, state, or local law or regulations, including disclosures that may be required under the 21st Century Cures Act.
- **Public Health Risks.** We may disclose medical information about you to public health authorities as required by law. As a general rule, we are required by law to disclose certain types of information to public health authorities, such as the Texas Department of State Health Services, in reporting certain communicable diseases.
- **Legal Matters and Law Enforcement.** If you are involved in a lawsuit or a legal dispute, we may disclose medical information about you in response to a court or administrative order, subpoena, discovery request, or other lawful process. In certain circumstances, we may disclose your medical information if we are asked to do so by law enforcement officials, or if we are required by law to do so.
- **Electronic Disclosures of Medical Information.** Under Texas law, we are required to provide notice to you if your medical information is subject to electronic disclosure. This Notice serves as general notice that we may disclose your medical information electronically for treatment, payment, or health care operations or as otherwise authorized or required by state or federal law.

### III. OTHER USES OF MEDICAL INFORMATION

- **Authorizations.** There are times we may need or want to use or disclose your medical information for reasons other than those listed above, but to do so we will need your prior authorization. Other than expressly provided herein, any other uses or disclosures of your medical information will require your specific written authorization.
- **Right to Revoke Authorization.** If you provide us with written authorization to use or disclose your medical information for such other purposes, you may revoke that authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your medical information for the reasons covered by your written authorization. You understand that we are unable to take back any uses or disclosures we have already made in reliance upon your authorization, and that we are required to retain our records of the care that we provided to you.

### IV. YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

- **Right to Inspect and Copy.** You have the right to inspect and/or copy your medical information that we have in our possession, which generally includes your medical and billing records.
- **Right to Amend.** If you feel the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by the Practice.

### V. CHANGES TO THIS NOTICE.

- As permitted by law, we reserve the right to change this Notice along with our privacy policies and practices. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well, as any information we receive in the future.

VI. COMPLAINTS.

- If you believe that your privacy rights as described in this Notice have been violated, you may file a complaint with the Practice. To file a complaint, you may either call or send a written letter. The Practice will not retaliate against any individual who files a complaint. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services.

VII. ACKNOWLEDGMENT AND REQUESTED RESTRICTIONS.

- By signing below, you acknowledge that you have received this Notice of Privacy Practices prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

SIGNATURES:

Patient/Legal Representative: \_\_\_\_\_

Date: \_\_\_\_\_

If Legal Representative, relationship to Patient: \_\_\_\_\_