

**CAPITAL VASCULAR SURGEONS & VEIN CENTER
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Notice of Privacy Practices

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

PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please call our office at the number listed above.
The effective date for this privacy notice is April 14, 2003.

At Capital Vascular Surgeons and Vein Center, we respect the privacy and confidentiality of your health information. This notice of Privacy practices ("Notice") describe how we may use and disclose your health/medical information and how you can get access to this information.

This notice applies to uses and disclosures we may make of all your health Information whether created or received by us.

I. OUR RESPONSIBILITIES TO YOU

We are required by law to:

1. Maintain the privacy of your health information and to provide you with notice of our legal duties and privacy practices.
2. Comply with the terms of our Notice currently in effect.

We reserve the right to change our practices and to make the new provisions effective for all health information we maintain including both health information we already have and health information we created or received in the future. Should we make material changes, we will make the revised Notice available by posting it (describe where you will post the revised Notice)

II. HOW WE WILL USE AND DISCLOSE YOUR HEALTH INFORMATION FOR TREATMENT AND HEALTH CARE OPERATIONS

We may use and disclose your health information for purposes of treatment, payment and health care operations as described below.

1. **For Treatment.** We may use and disclose your health information provide you with treatment and services and coordinate continuing care. Your health information may be used by doctors and nurses, as well as by lab technicians, dieticians, physical therapist or other personal involved in your care both within our office and with other health care providers involved in your care. For example, pharmacist will need certain information to fill a prescription ordered by your doctor. We may also disclose your health information to patients or facilities that will be involved in your care after you leave our care.
2. **For Payment.** We may use and disclose your health information so we can bill and receive payment for treatment and services you receive. For billing and payment purposes, we may disclose your health information to an insurance managed care company, Medicare, Medicaid, or other third party payor. For example, we may contact Medicare or your health plan to confirm your coverage or to request approval for a proposed treatment or service.
3. **For Health Care Operations.** We may use and disclose your health care information as necessary for our internal operations; such as for general administration activities and to monitor the quality of care you received, for education and training purposes, and for planning for services. Health information may be used to evaluate our employees and to review the qualifications and practices of doctors and other practitioners at Vascular Associates of Connecticut, LLC.

III. OTHER USES AND DISCLOSURES WE MAY MAKE WITHOUT YOUR WRITTEN AUTHORIZATION

Under Privacy Regulations, we may make the following uses and disclosures without obtaining written Authorization from you:

1. As required by law, we may disclose your health information when required by law to do so.
2. Unless you object we may use and disclose certain limited information about you in our directory while you are a patient. This information may include your name, your location, your general condition, and your religious affiliation. Our directory does not include specific medication information about you. We may disclose directory information, except for your religious affiliation, to people who ask for your name. We may provide the directory information, including your religious affiliation, to a

member of the clergy.

3. **Persons in Your Care or Payment for your Care.** Unless you object, we may disclose health information about you to a family member, close personal friend, or other persons you identify, including clergy, who is involved in your care. These disclosures are limited to information relevant to the person's involvement in your care or in arranging payment for your care.
4. **Public health Activities.** We may disclose your health information for public health activities.
5. **Reporting Activities of Abuse Neglect, or Domestic Violence.** If we believe that you have been a victim of abuse, neglect, or domestic violence we may use and disclose your health information to notify a government authority, if authorized by law or if you agree to the report.
6. **Health Oversight Activities.** We may disclose your health information to a health oversight agency for activities authorized by law. A health oversight agency is a state federal agency that oversees the health care system. Some of the activities may include for example audits, investigations, inspections and licensure actions.
7. **Judicial and Administrative Proceedings.** We may disclose your health information in response to a court or administrative order. We also may disclose information in response to a subpoena, discovery request, or other lawful process.
8. **Law Enforcement.** We may disclose your health information for certain law enforcement purposes, including for example to file reports required by law or to report emergencies or suspicious deaths, to comply with a court order, warrant, or other legal process; to identify or locate a suspect missing person; or to answer certain request for information concerning crimes.
9. **Coroners, Medical Examiners, Funeral Directors, Organ Procurement Organizations.** We may release your health information to a coroner, medical examiner, funeral director, and if you are an organ donor to an organization involved in the donations of organs tissue.
10. **Research.** Your health information may be used for research purposes but only if
 1. The privacy aspects of the research have been reviewed and approved by a special Privacy Board or Institutional Review Board and the board can legally waive patient authorizations otherwise required by the Privacy rule;
 2. the research is collecting information for a research proposal;
 3. the research occurs after your death; or
 4. if you give written authorization for the use or disclosure.
11. **To Avert a Serious Threat to Health or Safety.** When necessary to prevent a serious threat to your health safety or to the health safety of the public or another person, we may use or disclose your health information to someone able to help lessen or prevent the threatened harm.
12. **Military and Veterans.** If you are a member of the armed forces, we may use and disclose your health information as required by military command authorities. We may also use and disclose health information about you if you are a member of a foreign military as required by the appropriate foreign military authority.
13. **National Security and Intelligence Activities, Protective, Services for the President and Others.** We may disclose health information to authorized federal officials conducting national security and intelligence activities or as needed to provide

protection to the President of the United State, certain other persons or foreign heads of states or to conduct certain special investigations.

14. **Inmates/Law Enforcement Custody.** If you are an inmate of a correctional institution or under the custody of a law enforcement official we may disclose your health information to the institution or official for certain purposes including your own health and safety, as well as that of others.
15. **Workers' Compensation.** We may use or disclose your health information to comply with laws relating to workers' compensation or similar programs.
16. **Disaster Relief.** We may use or disclose health information about you to an organization assisting in a disaster relief effort.
17. **Appointment Reminders.** We may use or disclose information to remind you about appointments.
18. **Treatment Alternatives and Health-Related Benefits and Services.** We may use or disclose health information to inform you about treatment alternatives and health-related benefits and services that may be of interest to you.
19. **Business Associates.** We may disclose your health information to our business associates under Business Associate Agreement.

IV. **YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR ALL OTHER USES OR DISCLOSURES OF YOUR HEALTH INFORMATION**

1. We will obtain your written authorization (an "authorization") prior to making any use or disclosure other than those described above.
2. A written authorization is designed to inform you of a specific use or disclosure, other than those forth above, that we plan to make of your health information. The authorization describes the particular health information to be used or disclosed and the purpose of the use or disclosure. Where applicable, the written Authorization will also specify the name of the persons whom we are disclosing the health information. The Authorization will also contain an expiration date or event.
3. You may revoke a written authorization previously given by you at any time but you must do so in writing. If you revoke your Authorization, we will no longer use or disclose your health information for the purposes specified in that Authorization except where we have already taken actions in reliance on your Authorization.

V. **YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION**

You have the following rights regarding your health information.

1. **Right to request Restrictions.** You have the right to request that we restrict the way we use or disclose your health information for treatment, or health care operations; however we are not required to agree to a restriction. If we do agree to a restriction, we

will honor that restriction except in the event of an emergency and will only disclose the restricted information to the extent necessary for your treatment.

2. **Right to request confidential Communication.** You have the right to request that we communicate with you concerning your health matters in a certain manner or at a certain location. For example, you can request that we contact you only a certain phone number. We will accommodate your reasonable requests.
3. **Right of Access to Personal health Information.** You have the right to inspect and, upon written request obtain a copy of your health information except under certain circumstances. We may deny your request to inspect or receive copies in certain limited circumstances. If you are denied access to health information, in some cases you will have a right to request review of the denial. This view would be performed by a licensed health care professional designated by Capital Vascular Surgeons and Vein Center who did not participate in the decision to deny access.
4. **Right to Request Amendment.** You have the right to request that we amend your health information. Your request must be made in writing and must state the reason for the requested amendment We may deny your request for amendment if the information: A.- was not created by us, unless you provided reasonable information that the originator of the information is no longer available to act on your request. B is not part of the health information maintained by us; C is information to which you have a right of access; or d is already accurate and complete, as determined by us.

If we denied your request for amendment, we will give you a written denial notice including the reasons for the denial and explain to you that you have the right in submit a written statement disagreeing with the denial. Your letter of disagreement will be attached to your medical record.

5. **Right to an Accounting of Disclosures.** You may have the right to request an "accounting" of certain disclosures of your health information. This is a listing of disclosures made by us or by others on our behalf, but does not include disclosures for treatment, payment and health care operations, or other exceptions.

You must submit your request in writing and you must state the time period for which you would like the accounting. The accounting will include the disclosure date, the name of the person or entity that received the information and address, if known; a brief description of the information disclosed and a brief statement of the purpose of that disclosure. The first accounting provided within a 12-month period will be free; for further request, we may charge you our cost for completing the accounting.

6. **Right of a Paper Copy of this Notice.** You have the right to obtain a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time.

VI. SPECIAL RULES REGARDING DISCLOSURE OF PSYCHIATRIC SUBSTANCE ABUSE AND RELATED INFORMATION

For disclosures concerning health information related to care for psychiatric conditions, substance abuse, or HI-related information, special restrictions may apply. For example, we generally may not disclose this specially protected information response to a subpoena warrant or other legal process unless you sign a special authorization or a court orders the disclosure. A general release of your health information will not be sufficient for purposes of disclosing psychiatric, substance abuse or HIV -related information.

1. **Psychiatric Information.** We will not disclose records relating to a diagnosis or treatment of your mental conditions between the patient and psychiatrist or which are prepared at a mental health facility without specific written authorization or as required or permitted by law.
2. **HIV-related information.** HIV-related information will not be disclosed except under limited circumstances set forth under state or federal law, without your specific written Authorization. A general Authorization for release of medical or other information will not be sufficient for purposes releasing HIV-related information. As required by Connecticut law, if we make a lawful disclosure of HIV-related information, we will enclose a statement that notifies the recipient of the information that they are prohibited from further disclosing the information.
3. **Substance abuse treatment.** If you are treated in a specialized substance abuse program, information which could identify you as an alcohol or drug-dependent patient will not be disclosed without your specific authorization except for purpose of treatment or payment or where specifically required or allowed under state or federal law.

VII. COMPLAINTS

If you believe that your privacy rights have been violated, you may file a complaint in writing with us or with the Office of Civil Rights in the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W. Room 509F. HHH Building. Washington, DC 20201.

