

**CASCADE INTERNAL MEDICINE SPECIALISTS  
2239 NE Doctors Drive #200  
BEND, OR 97701**

**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.**

*If you have any questions about this notice, please contact our Practice Manager at 541-318-0124*

This notice describes the information privacy practices followed by our employees, staff, and other office personnel. The practices described in this notice will also be followed by physicians/providers with whom we have arranged to provide "call coverage" for our practice.

This notice applies to the information and records we have about your health, health status and the health care and services you receive at this office. Your health information may include information created and received by this office, may be in the form of written or electronic records or spoken words, and may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions and similar types of health-related information.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose your health information and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

We may use and disclose health information for the following reasons:

**For Treatment:** We may use your health information to provide you with medical treatment and coordination of care within or outside of our practice. We may need to disclose your health information to other providers, nurses, technicians, office staff, laboratories, imaging facilities, hospital facilities or other personnel who are involved in your health care.

**For Payment:** We may disclose your health information to submit billing to your health plan or a designated third party for payment of services you receive at this office. We may also be required to disclose your health information in order to obtain prior authorizations when required, or to determine whether your plan will cover the needed treatment.

**For Health Care Operations:** We may use and disclose your health information to run the practice and to ensure that all of our patients receive quality care. This may include our practice's inclusion in quality care initiative programs.

**Appointment Reminders:** We may contact you as a reminder that you have an appointment for treatment or medical care. We may leave a generic (non-specific as to medical information) appointment reminder messages on your voice-mail or with a person answering your phone.

SPECIAL SITUATIONS:

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

**To Avert a Serious Threat to Health or Safety:** We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

**Required By Law:** We will disclose health information about you when required to do so by federal, state or local law.

**Research:** We may use and disclose health information about you for health research projects.

**Organ and Tissue Donation:** If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

**Worker's Compensation:** We may release health information about you for workers' compensation claims.

**Public Health Risks:** We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

**Health Oversight Activities:** We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for state and federal agencies to monitor the health care systems, government programs, and compliance with civil rights laws.

**Legal Requests:** We may disclose health information about you in response to a court or administrative order, search warrant or subpoena.

**Law Enforcement:** We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

**National Security:** We may release health information for special government functions such as military, national security and presidential protective services.

**Coroners, Medical Examiners and Funeral Directors:** We may release health information to a coroner or medical examiner.

**Family and Friends:** We may disclose health information about you to your family members or friends if we obtain your written agreement to do so. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object and/or in the event you are not capable of giving consent due to your incapacity in a medical emergency.

#### **OTHER USES AND DISCLOSURES OF HEALTH INFORMATION:**

We can use and share health information about you through electronic health information exchanges so that information is readily available to participating healthcare providers, regardless of where they are treating you. Health information exchanges are also used to improve treatment, billing and operations.

You may choose to opt-out of healthcare providers accessing of your health information through the exchange. If you choose to do so, you must complete an opt-out form. This form can be obtained from our office.

#### **AUTHORIZATION:**

When you give us required Authorization to use or disclose health information about you, you may revoke that Authorization, **in writing**, at any time. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made.

If we have HIV, substance abuse information or genetic information about you, we cannot release that information without your specific written authorization.

#### **YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU:**

You have the following rights regarding health information we maintain about you:

**Right to Inspect and Copy:** You have the right to inspect and/or obtain a copy your health information. You must submit a written request to our office. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain circumstances.

**Right to Amend:** If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, you must complete and submit an amendment request form which can be obtained from to our office.

We may deny your request if you ask us to amend information that: a.) We did not create, b.) Is not part of the health information that we keep, c.) in our professional opinion is accurate and complete.

**Right to an Accounting of Disclosures:** You have the right to request an “accounting of disclosures”, if the disclosures are for purposes other than treatment, payment and health care operations. To obtain this list, you must submit your request **in writing** to our office. It must state a time period, which may not be longer than six years and may not include dates before October1, 2006.

**Right to Request Restrictions:** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care. **We are not required to agree to your request.** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you may complete the appropriate form which can be obtained from our office.

**Right to Request Confidential Communications:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. To request confidential communications, you may complete the required form which can be obtained from our office. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

**Right to a Paper Copy of This Notice:** You have the right to a paper copy of this notice. You may request a copy of this notice at any time and can also obtain a copy from our patient portal.

#### CHANGES TO THE TERMS OF THIS NOTICE:

We reserve the right to change this notice, and the changes will apply to all medical information we have about you as well as any information we receive in the future. A copy of the current notice will be available in our office and through our patient portal.

#### COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office:

Cascade Internal Medicine Specialists / Attention: Practice Manager  
2239 NE Doctors Drive #200  
Bend, OR 97701  
541-318-0124

Or:  
US Department of Health and Human Services, Office for Civil Rights  
200 Independence Ave. SW  
Washington, DC 20201  
877-696-6775

Or by visiting:  
[www.hhs.gov/ocr/privacy/hipaa/complaints](http://www.hhs.gov/ocr/privacy/hipaa/complaints)

**There will be no penalty or retaliation for filing a complaint.**