

## Central Jersey Orthopaedic Specialists

### NOTICE OF PRIVACY PRACTICES

Effective Date: 08/01/2013

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.

We are required by law to protect the privacy of health information that may reveal your identity, and to provide you with a copy of this notice, which describes the health information privacy practices of our medical group, its medical staff and affiliated health care providers who jointly perform health care services with our medical group, including physicians and physician groups who provide services at our facilities. A copy of our current notice will always be posted at all registration and/or admission points. You will also be able to obtain your own copies by accessing our website at [www.cjos.net](http://www.cjos.net) or calling the Privacy Officer at 908-561-2122.

*If you have any questions about this notice or would like further information, please contact the above referenced individuals.*

#### WHAT HEALTH INFORMATION IS PROTECTED

We are committed to protecting the privacy of information we gather about you while providing health-related services. Some examples of protected health information include information indicating that you are a patient of our medical group or receiving health-related services from our facilities, information about your health condition, genetic information, or information about your health care benefits under an insurance plan, each when combined with identifying information, such as your name, address, social security number or phone number.

#### REQUIREMENT FOR WRITTEN AUTHORIZATION

Generally, we will obtain your written authorization before using your health information or sharing it with others outside of our medical group. There are certain situations where we must obtain your written authorization before using your health information or sharing it, including:

**Marketing.** We may not disclose any of your health information for marketing purposes if our medical group will receive direct or indirect financial remuneration not reasonably related to our medical group's cost of making the communication.

**Sale of Protected Health Information.** We will not sell your protected health information to third parties. The sale of protected health information, however, does not include a disclosure for public health purposes, for research purposes where our medical group will only receive remuneration for our costs to prepare and transmit the health information, for treatment and payment purposes, for the sale, transfer, merger or consolidation of all or part of our medical group, for a business associate or its subcontractor to perform health care functions on our medical

group's behalf, or for other purposes as required and permitted by law.

If you provide us with written authorization, you may revoke that written authorization at any time, except to the extent that we have already relied upon it. To revoke a written authorization, please write to the Privacy Officer at our medical group. You may also initiate the transfer of your records to another person by completing a written authorization form.

#### HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR WRITTEN AUTHORIZATION

There are some situations when we do not need your written authorization before using your health information or sharing it with others, including:

##### 1. Treatment, Payment and Health Care Operations.

**Treatment.** We may share your health information with doctors or nurses at the medical group who are involved in taking care of you, and they may in turn use that information to diagnose or treat you. A doctor in our medical group may share your health information with another doctor to determine how to diagnose or treat you. Your doctor may also share your health information with another doctor to whom you have been referred for further health care.

**Payment.** We may use your health information or share it with others so that we may obtain payment for your health care services. For example, we may share information about you with your health insurance company in order to obtain reimbursement after we have treated you. In some cases, we may share information about you with your health insurance company to determine whether it will cover your treatment.

**Health Care Operations.** We may use your health information or share it with others in order to conduct our business operations. For example, we may use your health information to evaluate the performance of our staff in caring for you, or to educate our staff on how to improve the care they provide for you.

##### 2. Appointment Reminders, Treatment Alternatives, Benefits and Services.

In the course of providing treatment to you, we may use your health information to contact you with a reminder that you have an appointment for treatment, services or refills or in order to recommend possible treatment alternatives or health-related benefits and services that may be of interest to you.

**Coroners, Medical Examiners And Funeral Directors.** In the event of your death, we may disclose your health information to a coroner or medical examiner. We may also release this information to funeral directors as necessary to carry out their duties.

**Organ And Tissue Donation.** In the event of your death or impending death, we may disclose your health information to organizations that procure or store organs, eyes or other tissues so that these organizations may investigate whether donation or transplantation is possible under applicable laws.

7. **Completely De-identified Or Partially De-identified Information.** We may use and disclose your health information if we have removed any information that has the potential to identify you so that the health information is “completely de-identified.” We may also use and disclose “partially de-identified” health information about you if the person who will receive the information signs an agreement to protect the privacy of the information as required by federal and state law. Partially de-identified health information will *not* contain any information that would directly identify you (such as your name, street address, social security number, phone number, fax number, electronic mail address, website address, or license number).

8. **Incidental Disclosures.** While we will take reasonable steps to safeguard the privacy of your health information, certain disclosures of your health information may occur during or as an unavoidable result of our otherwise permissible uses or disclosures of your health information. For example, during the course of a treatment session, other patients in the treatment area may see, or overhear discussion of, your health information.

9. **Fundraising.** We may use or disclose your demographic information, including, name, address, other contact information, age, gender, and date of birth, dates of health service information, department of service information, treating physician, outcome information, and health insurance status for fundraising purposes. With each fundraising communication made to you, you will have the opportunity to opt-out of receiving any further fundraising communications. We will also provide you with an opportunity to opt back in to receive such communications if you should choose to do so.

10. **Changes to this Notice.** We reserve the right to change this notice at any time and to make the revised or changed notice effective in the future. We will notify you of any changes.

## **YOUR RIGHTS TO ACCESS AND CONTROL YOUR HEALTH INFORMATION**

*You have the following rights to access and control your health information:*

1. **Right To Inspect And Copy Records.** You have the right to inspect and obtain a copy of any of your health information that may be used to make decisions about you and your treatment for as long as we maintain this information in our records, including medical and billing records. To inspect or obtain a copy of your health information, please submit your request in writing to the Privacy Officer. If you request a copy of the information, we may charge a fee for the costs of copying

mailing or other supplies we use to fulfill your request. If you would like an electronic copy of your health information, we will provide you a copy in electronic form and format as requested as long as we can readily produce such information in the form requested. Otherwise, we will cooperate with you to provide a readable electronic form and format as agreed.

2. **Right To Amend Records.** If you believe that the health information we have about you is incorrect or incomplete, you may ask us to amend the information for as long as the information is kept in our records by writing to us. Your request should include the reasons why you think we should make the amendment. If we deny part or all of your request, we will provide a written notice that explains our reasons for doing so. You will have the right to have certain information related to your requested amendment included in your records.

3. **Right To An Accounting Of Disclosures.** You have a right to request an “accounting of disclosures,” which is a list with information about how we have shared your health information with others. To obtain a request form for an accounting of disclosures, please write to the Privacy Officer. You have a right to receive one list every 12-month period for free. However, we may charge you for the cost of providing any additional lists in that same 12-month period.

4. **Right to Receive Notification of a Breach.** You have the right to be notified if there is a probable compromise of your unsecured protected health information if the breach poses a significant risk of identity theft, financial, reputational or other harm to you within sixty (60) days of the discovery of the breach. The notice will include a description of what happened, including the date, the type of information involved in the breach, steps you should take to protect yourself from potential harm, a brief description of the investigation into the breach, mitigation of harm to you and protection against further breaches and contact procedures to answer your questions.

5. **Right To Request Restrictions.** You have the right to request that we further restrict the way we use and disclose your health information to treat your condition, collect payment for that treatment, run our normal business operations or disclose information about you to family or friends involved in your care. You also have the right to request that your health information not be disclosed to a health plan if you have paid for the services in full, and the disclosure is not otherwise required by law. The request for restriction will only be applicable to that particular service. You will have to request a restriction for each service thereafter. To request restrictions, please write to the Privacy Officer. We are not required to agree to your request for a restriction, and in some cases the restriction you request may not be permitted under law. However, if we do agree, we will be bound by our agreement unless the information is needed to provide you with emergency treatment or comply with the law. Once we have agreed to a restriction, you have the right to revoke the restriction at any time. Under some circumstances, we will also have the right to revoke the restriction as long as we notify you before doing so.

6. **Right To Request Confidential Communications.** You have the right to request that we contact you about your medical

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**ACKNOWLEDGMENT AND CONSENT**

*By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the medical group listed at the beginning of this notice, and how I may obtain access to and control of this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV-related information, alcohol and substance abuse treatment information, mental health information, and genetic information from my Health Care Provider. Finally, by signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of the medical group, its staff, and its business associates.*

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Signature of Patient or Personal Representative

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Print Name of Patient or Personal Representative

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Date

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Description of Personal Representative's Authority