PREMIER
DIABETES CARE

Premier Diabetes Care
16404 Smokey Point Blvd. STE 102,
Arlington, WA 98223

Notice of Privacy Practices

YOUR INFORMATION, YOUR RIGHTS, OUR RESPONSIBILITIES

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.

YOUR RIGHTS

You have the right to:

- Receive a copy of your electronic medical record
- Correct your electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Receive a list of those with whom we have shared your information
- Receive a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believed your privacy rights have been violated

YOUR CHOICES

You have a say with the way we use your information. You can allow us to:

- Share your information with family and friends
- Use non-sensitive information to market our services
- Use non-sensitive information for research or educational purposes

OUR USES AND DISCLOSURES

We may use and share your information as necessary to:

- Treat you
- Run our organization
- Contact you
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

YOU CAN RECEIVE AN ELECTROINIC OR PAPER COPY OF YOUR MEDICAL RECORD

- You can ask to see or receive an electronic or paper copy of your medical record and other health information we have on file. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

YOU CAN ASK US TO CORRECT YOUR MEDICAL RECORD

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we will tell you why in writing within 60 days.

YOU CAN REQUEST CONFIDENTIAL COMMUNICATIONS

- You may ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

YOU CAN ASK US TO LIMIT WHAT WE USE OR SHARE

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would negatively affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

YOU CAN GET A LIST OF THOSE WITH WHOM WE'VE SHARED

- You can ask for a list (accounting) of the times we have shared your health information for six years prior to the date you ask, who we share it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you ask us to make).
- We will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

YOU CAN GET A COPY OF THIS PRIVACY NOTICE

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

YOU CAN CHOOSE SOMEONE TO ACT FOR YOU

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has the authority to act for you before we take any action.

YOU CAN FILE A COMPLAINT IF YOU FEEL YOUR RIGHTS ARE VIOLATED

- You can complain if you feel we have violated your rights by contacting us using the information on found at the bottom of each page.
- You can file a complaint against us with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hippa/complaints/.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choice about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes

OUR USES AND DISCLOSURES

We typically use or share your health information in the following ways.

TO TREAT YOU

- We can use your health information and share it with other professionals who are treating you.
- Example: a doctor treating you for an injury asks another doctor about your overall health condition.

TO RUN OUR ORGANIZATION

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.
- Example: We use health information about you to manage your treatment and services.

TO CONTACT YOU FOR APPOINTMENT REMINDERS AND OTHER HEALTH-RELATED CARE

We may use your information to contact you to:

- Remind you that you have an appointment with us
- Schedule a follow up appointment
- Update you on the status of your medication/s
- Gather basic health related information
- Check-in with you regarding your care plan

BILLING FOR YOUR SERVICES

- We can use and share your health information to bill and get payment from health plans or other entities.
- Example: We give information about you to your health insurance plan so it will pay for your services.
- If you have paid out-of-pocket in full for service, you have the right to ask that your Protected Health Information with respect to that service not be disclosed to a health plan for purposes of payment or health care operations.

HOW ELSE CAN WE USE OR SHARE YOUR HEALTH INFORMATION?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes.
For more information see: www.hhs.gov/ocr/privacy/hippa/understanding/consumers/index/html.

TO HELP WITH PUBLIC AND SAFTEY ISSUES

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

TO DO RESEARCH

- We can use or share your information for health research.

TO COMPLY WITH THE LAW

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.

ADDRESS WORKERS' COMPENSATION, LAW ENFORCEMENT, AND OTHER GOVERNMENT REQUESTS

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hippa/understanding/consumers/noticepp.html.

Changes to the terms of this notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request.

If you have any questions regarding your Privacy Rights, please call 425-318-7144 or send an email to info@premierdiabetescare.com.

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HIPAA Disclosure Form

Patient Name: ____________________ Date of Birth: ____________

Preferred method of communication

☐ Phone: ____________________

☐ Email: ____________________

☐ Address: ____________________

May we leave a detail message? Yes ☐ No ☐

I, the patient name above, hereby authorize **Premier Diabetes Care** to release and discuss my medical information which may include, but not limited to appointments, diagnostic and laboratory results, diagnoses, medications, therapies, treatment plans, and account status with the following family members:

Name: ____________________ Relationship: ____________

Name: ____________________ Relationship: ____________

Name: ____________________ Relationship: ____________

Name: ____________________ Relationship: ____________

I, the patient, assign ____________________ to be the main contact person for communication and relaying messages regarding my care with **Premier Diabetes Care**.

I, the patient, understand that this authorization will be in good standing for one year from the signed date. However, I will be able to add or remove any one from this list at any given time by signing a new disclosure form.

Signature: ____________________ Date: ____________

Mailing Address:
16404 Smokey Point Blvd, STE 102
Arlington, WA 98223

Phone: (425) 318-7144
Email: Info@PremierDiabetesCare.com
Website: www.PremierDiabetesCare.com