

Frank P. Jircik, M.D.
12001 South Freeway, Suite 304
Burleson, Texas 76028

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 Lisa Jackson at 817-554-5100

WHO WILL FOLLOW THIS NOTICE?

All Physicians, Nurse Practitioners, Physician Assistants and all employees of the practice.

We understand that medical information about you and your health is personal, and are committed to protecting this information. When you receive care at Dr. Frank Jircik's office, a record of the care and services you receive is made. Typically, this record contains your treatment plan, history and physical, test results, and billing record. This record serves as a:

- Basis for planning your treatment and services;
- Means of communication among the physicians and other health care providers involved in your care;
- Means by which you or a third-party payor can verify that services billed were actually provided;
- Source of information for public health officials; and
- Tool for assessing and continually working to improve the care rendered.

This Notice tells you the ways we may use and disclose your Protected Health Information (referred to herein as "medical information"). It also describes your rights and our obligations regarding the use and disclosure of medical information.

OUR RESPONSIBILITIES.

Dr. Frank Jircik's office shall:

- Make every effort to maintain the privacy of your medical information;
- Provide you with notice of our legal duties and privacy practices with respect to information we collect and maintain about you;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction; and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.
- Dr. Jircik's office will notify you, and the Department of Health & Human Services, of any unauthorized acquisition, access, use or disclosure of your unsecured medical information that presents a significant risk of financial, reputation or other harm to you, to the extent required by law. Unsecured medical information means medical information not secured by technology that renders the information unusable, unreadable, or indecipherable as required by law.

THE METHODS IN WHICH WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe different ways we may use and disclose your medical information. The

examples provided serve only as guidance and do not include every possible use or disclosure.

For Treatment. We will use and disclose your medical information to provide, coordinate, or manage your health care and any related service. For example, we may share your information with your primary care physician or other specialists to whom you are referred for follow-up care.

For Payment. We will use and disclose medical information about you so that the treatment and services you receive may be billed and payment may be collected from you, an insurance company, or a third party. For example, we may need to disclose your medical information to a health plan in order for the health plan to pay for the services rendered to you.

For Health Care Operations. We may use and disclose medical information about you for office operations. These uses and disclosures are necessary to run this practice in an efficient manner and provide that all patients receive quality care. For example, your medical records and health information may be used in the evaluation of services, and the appropriateness and quality of health care treatment. In addition, medical records are audited for timely documentation and correct billing.

Appointment Reminders. We may use and disclose medical information in order to remind you of an appointment. For example, this practice may provide a written or telephone reminder that your next appointment is coming up.

Research. Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the surgical outcome of all patients for whom one type of procedure is used to those for whom another procedure is used for the same condition. All research projects, however, are subject to a special approval process. Prior to using or disclosing any medical information, the project must be approved through this research approval process. We will ask for your specific authorization if the researcher will have access to your name, address, or other information that reveals who you are, or will be involved in your care.

As Required by Law. We will disclose medical information about you when required to do so by federal or Texas laws or regulations.

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

Sale of Practice. We may use and disclose medical information about you to another health care facility or group of physicians in the sale, transfer, merger, or consolidation of our practice.

SPECIAL SITUATIONS.

- **Organ and Tissue Donation.** If you have formally indicated your desire to be an organ donor, we may release medical information to organizations that handle procurement of organ, eye, or tissue transplantations.
- **Military and Veterans.** If you are a member of the armed forces, we may release medical information about you as required by military command authorities.
- **Workers' Compensation.** We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Qualified Personnel.** We may disclose medical information for management audit, financial audit, or program evaluation, but the personnel may not directly or indirectly identify you in any report of the audit or evaluation, or otherwise disclose your identity in any manner.
- **Public Health Risks.** We may disclose medical information about you for public health activities. These activities generally include the following activities:
 - To prevent or control disease, injury, or disability;

- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and
- To notify the appropriate government authority if we believe you have been the victim of abuse, neglect, or domestic violence.

All such disclosures will be made in accordance with the requirements of Texas and federal laws and regulations.

- **Health Oversight Activities**. We may disclose medical information to a health oversight agency for activities authorized by law. Health oversight agencies include public and private agencies authorized by law to oversee the health care system. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, eligibility or compliance, and to enforce health-related civil rights and criminal laws.
- **Lawsuits and Disputes**. If you are involved in certain lawsuits or administrative disputes, we may disclose medical information about you in response to a court or administrative order.
- **Law Enforcement**. We may release medical information if asked to do so by a law enforcement official – In response to a court order or subpoena; or if the practice determines there is a probability of imminent physical injury to you or another person, or immediate mental or emotional injury to you.
- **Coroners, Medical Examiners and Funeral Directors**. We may release medical information to a coroner or medical examiner when authorized by law (e.g., to identify a deceased person or determine the cause of death). We may also release medical information about patients to funeral directors.
- **Inmates**. If you are an inmate of a correctional facility, we may release medical information about you to the correctional facility for the facility to provide you treatment.
- **Other Uses or Disclosures**. Any other use or disclosure of PHI will be made only upon your individual written authorization. You may revoke an authorization at any time provided it is in writing and we have not already relied on the authorization.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

You have the following rights regarding medical information collected and maintained about you:

- **Right to Inspect and Copy**. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records.
- To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at Dr. Frank Jircik's office. If you request a copy of the information, this office may charge a fee established by the Texas Medical Board for the costs of copying, mailing, or summarizing your records.
- Dr. Frank Jircik's office may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by our office will review your request and denial. The person conducting the review will not be the person who denied your request. Our office will comply with the outcome of the review.
- **Right to Amend**. If you feel that medical information maintained about you is incorrect or incomplete, you may ask this office to amend the information. You have the right to request an amendment for as long as the information is kept by Dr. Frank Jircik's office.

To request an amendment, your request must be made in writing and submitted to this office. In addition, you must provide a reason that supports your request.

Dr. Jircik's office may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, this office may deny your request if you ask us to amend information that:

- Was not created by our physicians or staff, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by our practice;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures made of your medical information for purposes other than treatment, payment, or health care operations.
- To request this list you must submit your request in writing to Lisa Jackson, Privacy Officer/Office Manager. Your request must state a time period, which may not be longer than six (6) years. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12-month period will be free. For additional lists within the 12-month period, you may be charged for the cost of providing the list. Dr. Frank Jircik's office will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information Dr. Frank Jircik's office uses or discloses about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care.

Dr. Frank Jircik is not required to agree to your request, unless the request pertains solely to a healthcare item or service for which Dr. Jircik's office has been paid out of pocket in full. Should this office agree to your request, we will comply with your request unless the information is needed to provide you emergency treatment.

- To request restrictions, your request should be in writing to Dr. Frank Jircik. In your request, you may indicate: (1) what information you want to limit; (2) whether you want to limit the use and/or disclosure; and (3) to whom you want the limits to apply.
- **Right to Request Confidential Communications.** You have the right to request that Dr. Frank Jircik communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that Dr. Frank Jircik contact you only at work or by mail.

To request that our office communicate in a certain manner, you must make your request in writing to the Privacy Officer. You do not have to state a reason for your request. Your request must specify how or where you wish to be contacted.

CHANGES TO THIS NOTICE.

We reserve the right to change our practices and to make the new provisions effective for all PHI we maintain. Should our information change, we will post the amended Notice of Privacy Practices in our office and on our website. You may request that a copy be provided to you by contacting the Privacy Officer.

COMPLAINTS.

If you believe your privacy rights have been violated, you may file a complaint with Dr. Frank Jircik's office or with the Office for Civil Rights, U.S. Department of Health and Human Services. To file a complaint with Dr. Frank Jircik's office, contact the Privacy Officer at 817-551-5400. Your complaint must be filed within 180 days of when you knew or should have known that the act occurred. The address for the Office of Civil Rights is:

*Secretary of Health & Human Services
Region VI, Office for Civil Rights
U.S. Department of Health and Human Services
1301 Young Street, Suite 1169
Dallas, TX 75202*

All complaints should be submitted in writing.

You will NOT be penalized for filing a complaint.

ACKNOWLEDGEMENT

Patient Name: _____

Date of Birth: _____

I acknowledge that Dr. Frank Jircik's office provided me with a written copy of the office NOTICE of Privacy Practices.

I also acknowledge that I have been given the opportunity to read the Notice of Privacy Practices and ask questions.

Patient Signature

Date

Personal Representative Signature (if applicable)

Relationship to Patient

Dr. Frank Jircik

12001 South Freeway, Suite 304
Burlson, Texas 76028
Office 817-551-5400 Fax 817-568-0961

HIPAA ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

TO THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, HEALTH CARE OPERATIONS, AND AS OTHERWISE ALLOWED BY LAW.

Dr. Frank Jircik’s office will maintain a record of the care and services you receive at our practice. This consent only covers your protected health information created while you are a patient of Dr. Frank Jircik’s. Your protected health information pertains to your diagnosis and/or treatment at this practice, including but not limited to information concerning mental illness (except for psychotherapy notes), use of alcohol or drugs or communicable diseases such as Human Immunodeficiency Virus ("HIV"), and Acquired Immune Deficiency Syndrome ("AIDS"), laboratory test results, medical history, treatment progress or any other such related information.

Our *Notice of Privacy Practices* provides information about how this practice and its physicians may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. **By signing this form, you acknowledge receipt of a copy of Dr. Jircik’s, Notice of Privacy Practices, and that you had the opportunity to review it before signing this Consent.** By signing this document, you also consent to our use and/or disclosure of protected health information about you for treatment, payment, health care operations and as otherwise allowed by law.

You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we have already used or disclosed your protected health information in reliance on your consent.

Signature of Patient, legal guardian or patient's representative Signature of Witness

Date