



1910 Highway 35 South • Oakhurst, NJ 07755 • Phone: 732-531-0100 •
Fax: 732-531-0144 Web: www.familyfirst-urgentcare.com

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Commitment To Your Privacy

Our practice is dedicated to maintaining the privacy of your individual identifiable health information (also called protected health information, or PHI.). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We are also required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at this time.

We realize that these laws are complicated but we must provide you with the following important information:

- How we may use and disclose your PHI
- Your privacy rights in your PHI
- Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past or for any records that we may create and maintain in the future. Our practice has posted a current Notice in our office and you may request a copy of our most current Notice at any time.

Use and Disclosures of Protected Health Information

We can use or disclose your PHI for many purposes including treatment, payment, and health care operations. The following categories described a few different ways in which we may use and disclose your PHI.

- **TREATMENT:** Our practice will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. For example, we might use your PHI in order to write a prescription for you. We will also disclose your PHI to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.
- **PAYMENT:** Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits, and we may provide your insurer with details regarding your treatment to determine if your insurer will cover your treatment. We may use your PHI to bill you directly for services and items. We may also



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disclose your PHI to other healthcare providers and entities to assist in their billing and collecting efforts.

- **HEALTH CARE OPERATIONS:** Our practice may use and disclose your PHI to operate our business. Examples of the ways in which we may use and disclose your information include but are not limited to: the evaluation of the quality of care you receive from us or to conduct cost-management and business planning activities for our practice.
- **RELEASE OF INFORMATION TO FAMILY/FRIENDS:** Our practice may allow your family members or friends to act on your behalf and may release PHI to them when we determine in our professional judgment that it is in your best interest to make such disclosure.

Special Situations

The following categories describe unique scenarios in which we may use or disclose your PHI.

- **WORKERS' COMPENSATION:** Our practice may disclose and release health information about your work related illness or injury to comply with worker's compensation laws.
- **PUBLIC HEALTH RISKS:** Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:
 - Prevent or control disease, injury, or neglect
 - Report births and deaths
 - Report child abuse or neglect
 - Notifying a person regarding potential exposure to communicable disease or if they are at risk of contracting or spreading a disease
 - Notifying appropriate government agencies regarding potential abuse or neglect of an adult patient. We will only make this disclosure if the patient agrees or when required by law
- **HEALTH OVERSIGHT ACTIVITIES:** Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include investigations, inspections, audits, licensure and disciplinary actions; civil, administrative, and criminal procedures; or other activities necessary for the government to monitor government program and health care system.
- **MILITARY AND VETERANS:** Our practice may release your PHI as required by military command authorities.
- **LAWSUIT AND DISPUTES:** Our practice may use and disclose your PHI in response to a court or administrative order if you are involved in a lawsuit or dispute. We may also disclose your PHI in response to a subpoena, discovery request, or other lawful process by another party involved in the dispute but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.
- **LAW ENFORCEMENT:** Our practice may release PHI if asked to do so by a law enforcement official:
 - In response to a court order, subpoena, warrant, summons, or similar process
 - To identify or locate a suspect, fugitive, material witness, or missing persons
 - Regarding criminal conduct on our premises
 - Concerning a death we believe has resulted from criminal conduct
 - To report a crime (including location or victims of the crime, or the identity, description, or location of the person who committed the crime)



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- **CORONERS, MEDICAL EXAMINERS, AND FUNERAL DIRECTORS:** Our practice may release your PHI to a coroner or medical examiner. Such disclosures may be necessary to identify a deceased person or determine the cause of death. We may also release PHI to funeral directors as necessary to carry out their duties.

Your Health Information Rights

You have the following rights regarding the PHI that we maintain about you:

- Obtain a copy of this notice of information upon request.
- Request communication of your health information by alternative means or at alternative locations.
- Request restrictions on certain uses and disclosures of your PHI to only certain individuals involved in your care or the payment for your care. We are not required to agree to your request; however if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. Your request must be clear and concise on the information you wish restricted, whether you are requesting to limit our practice's use and disclosure, and to whom you want the limits to apply.
- Inspect and obtain a copy of the PHI including medical records and billing records.
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.
- Amend your health record if you believe it is incorrect or incomplete. To request an amendment, your request must be made in writing and submitted to Practice Administrator, 1910 Highway 35 South, Oakhurst, NJ 07755. You must provide us with a reason that supports your request for amendment. We may deny your request if you ask us to amend information that in our opinion is: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.
- You have a right to notice in the event a breach occurs affecting your unsecured Protected Health Information. We make every effort to safeguard the privacy and security of your Protected Health Information as required by law.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the company's Practice Administrator, 1910 Highway 35 South, Oakhurst, NJ 07755 or at (732) 531-0100.

If you believe your privacy rights have been violated, you can file a complaint with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint the Office for Civil Rights. The address for the OCR is: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independent Avenue, S.W., Room 509F, HHH Building, Washington, DC 20201

ACKNOWLEDGEMENT OF RECEIPT OF HIPPA NOTICE OF PRIVACY PRACTICES



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By signing this document I acknowledge that I have read and received a copy of the HIPAA Notice of Privacy Practices

Printed Name Patient Signature _____ / ____ / ____
Date

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PLEASE CHECK ALL THAT APPLY

I authorize my physician/clinical staff to disclose my protected health information to:

- Myself only M
- My spouse or significant other (specify names) _____ M
- My parent(s) (specify names) _____ M
- Others (please specify relationship) _____ O

I would like to be contacted in the following manner:

- Home Telephone _____ H
 - OK to leave message with detailed information O
 - Leave message with call-back number only L
 - Do not leave messages or medical information D
- Cellular Telephone _____ C
 - OK to leave message with detailed information O
 - Leave message with call-back number only L
 - Do not leave messages or medical information D
- Work Telephone _____ W
 - OK to leave message with detailed information O
 - Leave message with call-back number only L
 - Do not leave messages or medical information D



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- Written Communication W
- OK to email through our patient portal O
- OK to mail to my home address O

I grant Family First Urgent Care permission to obtain information from external sources (Pharmacy) regarding medications that have been prescribed to me.

- [Check here if you DO NOT consent for external prescription history]

_____/_____/_____
Patient Signature Date