

NOTICE OF INFORMATION PRACTICES

Owen Drive Surgical Clinic of Fayetteville is dedicated to protecting your medical information. We are required by law to maintain the privacy of protected health information and to provide you with this Notice of our legal duties and privacy practices with respect to protected health information. This notice describes how information about you may be used and disclosed and how you can gain access to this information. We are required by law to abide by the terms of this Notice. Please review it carefully.

1. Owen Drive Surgical Clinic of Fayetteville may use and disclose protected health information for treatment, payment and healthcare operations. Examples of these include, but are not limited to, referral to nursing homes, home health agencies and/or referral to other providers for treatment. Payment examples include, but are not limited to, insurance companies for claims including coordination of benefits with other insurers; collection agencies. Healthcare operations include, but is not limited to, internal quality control and assurances including auditing of records.

2. Owen Drive Surgical Clinic of Fayetteville is permitted or required to use or disclose protected health information without the individual's written consent or authorization in certain circumstances. Two examples of such are for public health requirements or court orders.

3. Owen Drive Surgical of Fayetteville will not make any other use or disclosure of a patient's protected health information without the individual's written consent or authorization. Such authorization may be revoked at any time. Revocation must be written.

4. Owen drive Surgical Clinic of Fayetteville will abide by the terms of this notice currently in effect at the time of the disclosure.

5. Owen Drive Surgical Clinic of Fayetteville reserves the right to change the terms of its notice and to make new notice provisions effective for all protected health information that it maintains. Owen Drive Surgical Clinic will provide each patient with a copy of any revisions of its Notice of Information Practices at the time of their next visit or at their last known address if there is a need to use or disclose any protected health information of the patient. Copies may also be obtained at any time at our office. The notice will also be posted in the reception area.

6. Any patient or guardian has the right to object to the use of their health information for directory purposes.

7. Any patient or guardian has the right to request to inspect and obtain copies of their medical record.

8. Any patient or guardian has the right to request amendments be made to their medical record.

9. Any patient or guardian has the right to request a six-year accounting of all disclosures of their medical record. The history will be provided within 60 days of the request and a reasonable charge may be assessed for any copies after the first requested in a 12-month period.

10. Any patient or guardian has the right to request restrictions as to how their health information may be used or disclosed to carry out treatment, payment or healthcare operations. The Practice is not required to agree to the restrictions requested, but if the Practice does agree, the Practice must abide by those restrictions.

11. Any person/patient may file a complaint to the Practice or to the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with the Practice, please contact the Privacy Officer at the following address and or phone number:
Owen Drive Surgical Clinic of Fayetteville, 513 Owen Drive, Fayetteville, NC 28304 Telephone: 910-323-0101 Fax: 910-484-2654. All complaints will be addressed and the results will be reported by the Privacy Officer.

12. It is the policy of Owen Drive Surgical Clinic of Fayetteville that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance of the privacy standards.

The effective date: _____ Name of Patient: _____

Signature of Patient or Legal Guardian _____ Date: _____