

HomeChoice Partners Notice of Privacy Practices

PATIENT NAME: _____ ID# _____

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.

HomeChoice Partners is providing this Notice of Privacy Practices because the privacy of your health information is very important to you and to us, and in compliance with Federal regulations. By "your health information" we mean the information that we maintain that specifically identifies you and your health status. This Notice describes how we use your health information within HomeChoice Partners and disclose it outside HomeChoice Partners and why. This Notice covers:

- Uses or Disclosures which do not require your written authorization.
 - * Treatment, payment, and health care operations.
 - * Uses or Disclosures of your health information to which you may object.
 - * Uses or Disclosures required or permitted.
- Uses or Disclosures which require your written authorization.
- Your rights as a patient regarding privacy of your health information.
- Our duties in protecting your health information.
- Complaints, contact person, effective date, and acknowledgment.

Uses or Disclosures Which Do Not Require Your Written Authorization

We use or Disclose your health information to carry out your treatment; to obtain payment for your treatment; and to conduct health care operations. For example:

For treatment, we use your health information to fill your prescriptions and provide infusion services. We disclose your health information for treatment purposes to physicians and other health care professionals outside our company who are involved in your care.

For payment, we use your health information to prepare documentation required by your insurance company or HMO or by Medicare or Medicaid. We disclose that part of your health information that these organizations require to pay us.

For health care operations, we use or disclose your health information, for example, to improve the quality of our services, to plan better ways of serving patients, and to evaluate staff performance.

Uses or Disclosures Required or Permitted

Where we are required or permitted to do so, we may use or disclose your health information in the following circumstances **without** your written authorization.

Federal, state or local law requirements. Federal government investigation, when required by the Secretary of Health and Human Services to investigate or determine our compliance with federal regulation. Judicial or administrative proceedings, for example responding to a court order or subpoena.

Public health activities, for example to report communicable disease or death; or for the matters involving the Food and Drug Administration.

Health oversight activities by a health oversight agency. (A health oversight agency is an organization by the government to oversee eligibility and compliance and to enforce civil rights laws.)

Law enforcement purposes, for example to report certain types of wounds or other physical injuries or to identify or locate a suspect, fugitive, material witness, or missing person. Reporting of abuse, neglect or domestic violence.

Averting a serious threat to your health or safety or that of the public. Specialized government functions such as military or veterans' affairs; national security, and intelligence activities.

Workers' compensation.

Uses or Disclosures of Your Health Information to Which You May Object

We may use or disclose your health information for the following purposes, unless you ask us not to.

- Informing family and friends. We may disclose your health information to family, friends, or others identified by you who are involved in your case.
 - Assistance in disaster relief efforts.
 - Confirming our visits to your home or other appointments.
 - Informing you about treatment alternatives or other health-related benefits and services that may be of interest to you.
- If you object to our use of health information for any of these purposes please contact:

HomeChoice Partners

Attn: Director of Patient Care Services
5365 Robin Hood Road, #200, Norfolk, VA 23513
(800) 745-7764

Uses or Disclosures which Require Your Written Authorization

Your written authorization, which you may revoke (**in writing**), is required if we use or disclose your health information for any purpose other than those stated above. In particular your authorization is required if; We use or disclose your health information for marketing of goods or services.

Your Rights As a Patient of Your Health Information

Rights to Request Restriction: You have the right to request restrictions on our use and disclosures of your health information; however we may refuse to accept the restriction.

Right to Request Confidential Communications: You have the right to request that we communicate with you confidentially, for example to speak with you only in private; to send mail to an address you designate; or to telephone you at a number you designate. **Your request must be in writing.** We will make every attempt to honor your request.

Right to Request Access to Your Health Information: You have the right to request access to your health information in order to inspect or copy it. **Your request must be in writing.** We may deny your request and, if so, you may request a review of the denial. However, we will make every attempt to honor your request.

Right to Request an Amendment of Your Health Information: You have the right to request an amendment to your health information. **Your request must be in writing** and must provide a reason for the amendment. We may deny your request and, if so, you may submit a statement of disagreement. However, we will make every attempt to honor your request.

Right to Request an Accounting of Disclosures of Your Health Information: You have the right to request an accounting of our disclosures of your health information for purposes other than treatment, payment, and health care operations. We will make every attempt to honor your request. We are not required to provide an accounting for disclosures before April 14, 2003 or for more than 6 years prior to the date of your request.

Right to Obtain a Paper Copy of this Notice: If you received this Notice electronically, you have the right to receive a paper copy. To exercise any of these rights or to obtain a copy of this notice please call or write:

HomeChoice Partners
5365 Robin Hood Road, #200, Norfolk, VA 23513
Attn: Director of Patient Care Services
(800) 745-7764

Our Duties in Protecting Your Health Information

We are required by law to maintain the privacy of your health information. We must inform patients or their legal representatives of our legal duties and privacy practices with respect to health information. This Notice discharges that duty. We must abide by the terms of the Notice currently in effect. We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that we maintain. At any time, you may obtain a copy of the current notice by writing:

HomeChoice Partners
Attn: Director of Patient Care Services
5365 Robin Hood Road, #200, Norfolk, VA 23513
Or on our website: www.HomeChoicePartners.com

Complaints, Contact Person, Effective Date, and Acknowledgment

You may complain to us and to the Secretary of Health and Human Services if you believe your privacy rights have been violated.

HomeChoice Partners
Attn: Director of Patient Care Services
5365 Robin Hood Road, #200, Norfolk, VA 23513

and,

The Secretary of Health and Human Services
Attn: U.S. Dept. of Health & Human Services
200 Independence Ave. SW, Washington, D.C. 20201
(source: www.hhs.gov)

(You will NOT be retaliated against for filing a complaint.)

Acknowledgment of Receipt of HomeChoice Partners Notice of Privacy Practices

I have received a copy of:
The HomeChoice Partners Notice of Privacy Practices.

Signature of Patient Date

-Or- Signature of Personal representative Date

Relationship to patient _____

If HomeChoice Partners' employee is unable to obtain above required signature:

Please check below the reason signature was not obtained:

- Patient too sick to sign at this time.
- Patient would not sign.
- Other: _____

HomeChoice Partners employee attempting unsuccessfully to obtain signature:

Name / Date

- 1) Except in an emergency treatment situation the infusion company must make a good faith effort to obtain the signature of the patient or personal representative acknowledging receipt of the Notice.
- 2) If the signature cannot be obtained, the company must document its efforts to obtain the signature and the reason why the signature was not obtained.

This Notice is Effective April 14, 2003

HCP Privacy Notice 2003 All Rights Reserved