Cornerstone Family Care, PC

2750 Clay Edwards Drive • Suite 612
North Kansas City, MO 64116
Phone: (816) 221-7744 • Fax: (816) 221-7755

NOTICE OF PRIVACY PRACTICES

State and Federal laws require us to maintain the privacy of your health information and to inform you or our privacy practices by providing you with this notice. 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.

It is our right to change our privacy practices provided the law permits the changes. Before we make a significant change, this Notice will be amended to reflect the change(s) and we will make the new notice available upon request. If you have any questions about this notice, please contact our office manager.

OUR PLEDGE REGARDING MEDICAL INFORMATION:

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive in our practice. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care. This notice will tell you about the ways in which we may use and disclose medical information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of medical information. We are required by law to:

* make sure that medical information that identifies you is kept private;
* give you this notice of our legal duties and privacy practices with respect to medical information about you; and
* follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION

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

Abuse and Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent serious threat to your health or safety or to the health or safety of others.

Appointment Reminders: We may use and disclose medical information to contact you as a reminder that you have an appointment; including but not limited to voice mail messages, postcards or letters.

Disclosure: We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you. Different departments of our practice also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays.

Emergencies: We may release medical information about you to a friend or family member who is involved in your medical care. We may also tell your family or friends your condition. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Healthcare Operations: We will use and disclose your information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to; medical records staff, outside health or management reviewers and individuals performing similar activities.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counter intelligence or other national security activities, we may disclose it to authorized federal officials.

Organ and Tissue Donation: If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Payment: We may use and disclose medical information about you so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about treatment you received so your health plan will pay us or reimburse you. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

Public Health Responsibilities: We will disclose your PHI to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent/control disease, injury and/or disability.

Required by Law: We will disclose medical information about you when required to do so by federal, state or local law.

Treatment: We may use medical information about you to provide you with medical treatment or services. Everyone one on our staff is required to sign a confidentiality statement.

YOUR RIGHTS:

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are the legal guardian). There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request form. You may also request access by sending a letter to the address at the end of this notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be charged at the current copy rate approved by the State, along with applicable staff time involved in copying records, if allowed. If you desire copies be mailed to you, postage will be charged. If a report is desired, the applicable fee for report completion will be charged (see privacy officer for the current rate of such a report).

Amendment: You have the right to amend your healthcare information if you feel it to be inaccurate or incomplete. Your request; however, must be in writing and must include an explanation of why the information should be amended. Under certain circumstances your request may be denied.

Non routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. You have the right to a list of instances where we, or a business associate, disclosed information for reasons other than treatment, payment or healthcare operations. You can request non-routine disclosures going back six years starting on April 14, 2003. Information prior to that date would not have to be released.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement (except in cases of emergency). Please contact our Privacy Officer if you want to further restrict access to your health care information. This request MUST be made in writing, by you.

Questions and/or Complaints: You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to the Privacy Officer. If you feel we have violated your privacy rights, or if you disagree with a decision we made regarding your access to your PHI, you can complain to us, in writing. We support your right to the privacy of your health information and will not retaliate in any way if you choose to file a complaint either with us, or with the U.S. Department of Health and Human Service(s).

Practice Name: Cornerstone Family Care
Privacy Officer: Practice Manager
Telephone: 816-221-7744 Fax: 816-221-7755
Address: 2750 Clay Edwards Drive Suit 612
North Kansas City, MO 64116

Cornerstone Family Care

Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations

I understand that as part of my health and medical care, Cornerstone Family Care originates and maintains medical and health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I further understand that this information serves as:
* a basis for planning my care and treatment
* a means of communication among the health professionals who contribute to my care
* a source of information for applying my diagnosis and treatment information to my bill
* a means for a third party payer to verify that services were billed as actually provided
* and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I further understand and agree that this agreement to release information shall apply to all information accumulated up to this date and to any information acquired in the future. This agreement to release future information shall remain in force until such time as I shall revoke it in writing.

I understand and have been provided with a **PATIENT PRIVACY NOTICE** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the **PATIENT PRIVACY NOTICE** prior to signing this consent. I understand that Cornerstone Family Care reserves the right to change their notice and practices, but that prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and Cornerstone Family Care is not required to agree to the restrictions requested. I understand that I must revoke this consent in writing, except to the extent the organization has already taken action in reliance thereon.

By Missouri law we are required to notify you…that the information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

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Signature of Patient or Legal Representative Date Notice Effective