

**Dermatology Associates of Atlanta, P.C.**  
Dermatology & Skin Cancer Center  
Atlanta Laser & Cosmetic Surgery Center  
Griffin Center for Hair Restoration & Research  
Laser Institute of Georgia  
Skin Medics™ Medical Spa  
Atlanta Center for Veins  
Psoriasis Treatment Center  
Surgical Suite  
Revised 2-24-2010

**THIS NOTICE DETAILS HOW MEDICAL INFORMATION THAT INDIVIDUALLY IDENTIFIES YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY AS THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.**

\*Any questions regarding the contents of this notice should be directed to our Privacy Officer Sharon Williams. Please see the contact information at the bottom of this brochure.

**OUR LEGAL DUTY**

Under the Health Insurance Portability Accountability Act of 1996 ("HIPAA"), we are required to maintain the privacy of your protected health information. In accordance with the State of Georgia and federal law, we are required to give you notice about our privacy practices, your legal duties, and your rights concerning your medical information.

**PERSONS COVERED BY THIS NOTICE**

Dermatology Associates of Atlanta and the Surgical Suite provide health care to our patients and clients in partnership with other physicians, professionals, and organizations. These entities may share medical information with each other to ensure correct treatment, payment, and business operations. The following are persons covered by this notice:

- All employees and staff of Dermatology Associates of Atlanta, P.C., the Surgical Suite, or any of its divisions listed above including: medical assistants, volunteers, nursing staff, support staff, business associates/ partners, and administrative services with which we share health information.
- Persons or entities performing services for Dermatology Associates of Atlanta, P.C., the Surgical Suite, or any of its divisions listed above, under agreement containing privacy protections.
- Persons or entities with whom Dermatology Associates of Atlanta, P.C., the Surgical Suite, or any of its divisions listed above participates in managed care arrangements.
- Members of the Medical Staff and other medical professionals involved in your care, performing peer review, quality improvement, medical education, and/or other support type services.

## OUR COMMITMENT TO YOU

- We will keep your medical information private.
- We will give you notice of our legal duties and privacy practices regarding your personal medical information.
- We will follow the terms of this notice.

**\*IMPORTANT NOTICE:** Dermatology Associates of Atlanta, P.C., the Surgical Suite, or any of its aforementioned divisions reserves the right to amend this notice of privacy practices. Any amendment made to this notice will affect any records produced in the future or currently maintained by our practices which contain your personal health information. Our offices will make efforts to keep you aware of any amendments by posting a current copy of this notice in a visible location and making a paper copy of this notice available to all patients.

## DISCLOSURE OF YOUR MEDICAL INFORMATION

**Treatment:** We may use your medical information to provide you with medical treatment. We may disclose medical information about you to doctors, nurses, technicians, health care staff, or other personnel involved in your care. We may also disclose your medical information to other healthcare facilities should you require transfer to a hospital or additional treatment center. We may also disclose your medical information to health care providers outside of our facilities that are involved in your care after you leave Dermatology Associated of Atlanta, P.C., the Surgical Suite, or any of its aforementioned divisions.

**\* IMPORTANT NOTICE:** Dermatology Associates of Atlanta, P.C., the Surgical Suite, or any of its aforementioned divisions may share your medical information with outside physicians and/or medical facilities. These physicians and medical facilities are independent medical professionals. While these professionals may follow this notice, or their own privacy policy, they are independent professionals. Dermatology Associates of Atlanta, P.C., the Surgical Suite, and all of its divisions listed above expressly disclaim any responsibility or liability for their acts or omissions.

**Payment:** We may disclose your medical information so that the treatment and services you receive can be billed and collected from you, your insurance company, or another third party. We may inform your health plan about a treatment you are going to receive in order to obtain prior approval, and ensure payment coverage, for the treatment(s).

**Operations, Health Care:** We may disclose your medical information for business operations including: risk management evaluations, internal quality studies, peer reviews, compliance with licensure, and accreditation or certification requirements. We may disclose health information to doctors, nurses, technicians, or other personnel for teaching purposes. We may also gather patient medical information to determine what new services we should offer and whether new services are cost effective.

**Business Associates:** We may share access to your health information with third party “business associates” (i.e. - independent marketing companies hired to direct the practices’ advertising and marketing efforts.) These “business associates” have signed agreements that require them to maintain the same high standards of safeguarding your privacy that we require of all our employees and divisions.

**DAA Medical Divisions:** All divisions of Dermatology Associates of Atlanta, P.C. are under the management of our administrative and medical directors. All standards of privacy equally apply to all divisions operated by Dermatology Associates of Atlanta, P.C.

**Family and Friends:** We may release information to the person named as your Durable Power of Attorney for Health Care, individuals empowered by state or federal law to make health-related decisions for you, or any other person you identify as being involved with your care or payment for your care. Additionally, we may disclose your medical information to entities assisting in disaster relief efforts so that your family can be notified about your condition.

**Minors:** If you are under 18 years of age, we may release certain types of information to your parents or guardian in accordance with applicable state and federal law.

**Research:** We may use and disclose your medical information for research, clinical trials, and experimental drugs. Most research projects require your permission if researchers involved in your care will have access to your name, address, or other information that personally identifies you. However, the Internal Review Board and Privacy Board have determined that your permission is **not** required if the research presents minimal risk of exposing your private information and the following measures have been taken:

- A.) A passable plan is implemented to protect personal identifiers from improper usage or disclosure.
- B.) Written assurances have been given that personal identifiers will not be re-exposed or disclosed to individuals involved in the authorized oversight of additional research (with the exception of exposure required by law.)
- C.) A passable plan is implemented to destroy personal identifiers as soon as research will allow (with the exception of identifiers retained as required by law.)

**Threats to Health and Safety:** In accordance with federal and state law, we require the disclosure of health information that poses a serious threat to the health and safety of you as an individual, the people around you, or the general public. We will only disclose this information to persons associated with threat prevention organizations. Additionally, we comply with all laws regarding child abuse, report of diseases, and injuries to state or federal agencies.

**Active Military and Veterans:** Per military command, we may disclose personal health information if you are a member of the U.S. or foreign armed forces.

**Workers’ Compensation:** We may disclose personal health information to a benefits provider for work-related injuries and illnesses to the extent necessary for compliance with workers’ compensation law.

**Law Enforcement:** We may disclose health information upon request from a local, state, or federal law enforcement official regarding the following:

- A.) A death resulting from believed criminal conduct.
- B.) Criminal conduct at our offices.
- C.) Response to legal processes (i.e. - subpoena, court order, warrant, etc.)
- D.) Location or identification of missing persons, suspects, fugitives, or material witnesses.
- E.) A crime victim whose direct agreement is unable to be obtained.

**National Security:** We may disclose health information to federal officials regarding: intelligence activities authorized by law, national officials or heads of state, and the conduction of investigations.

**Inmates:** We may disclose your health information if you are an inmate of a correctional institution, or if you are under the custody of a law enforcement official. Your information will only be disclosed if the aforementioned release is necessary in providing you with health care, to protect your health and safety, or to protect the health and safety of others (i.e. - the safety of law enforcement officers or that of your respective correctional institution.)

#### **OPTIONAL DISCLOSURES**

While not required, patients may agree to disclose their personal health information for the following purposes:

**Appointment Reminders:** We may disclose your health information to contact you and remind you of previously scheduled appointments.

**Additional Benefits and Services:** We may disclose your health information to inform you of additional treatment alternatives and options that may be of interest to you.

**Deceased Patients:** We may disclose health information to a medical examiner or coroner to correctly identify a deceased individual. We may also disclose health information to determine the cause of a death. Additionally, we may disclose health information to aid a funeral director in the performance of their job.

**Treatment Options:** We may disclose your health information to inform you of potential treatments or alternatives that would add to your plan of care.

**Tissue and Organ Donation:** If you are an organ donor, we may disclose your health information to organizations that handle eye, organ, or tissue procurement or transplant. This includes donation banks and facilities aiding in transplant.

#### **YOUR PERSONAL HEALTH INFORMATION RIGHTS**

As a patient of Dermatology Associates of Atlanta, P.C., the Surgical Suite, or any of its aforementioned divisions, you have a right to the following regarding your personal health information:

**Accounting of Disclosures:** As a patient, you have the right to request an “accounting of disclosures statement.” An “accounting of disclosures statement” is a list of any non-routine disclosures made containing your personal health information for purposes other than those detailed in the **DISCLOSURE OF YOUR MEDICAL INFORMATION** section of this notice. To obtain an “accounting of disclosures statement”, you must submit a written request containing your name, contact information, and a time period for which you are requesting information about to our Privacy Officer Sharon Williams. This time period may not exceed 10 years from the date of disclosure for adult patients, or until minor patients reach the age of 21 (whichever comes first.) Each patient is entitled to one “accounting of disclosures statement” within a 12-month period.

**Amendment:** As a patient, you have the right to submit a request to amend any personal health information you deem incomplete or inaccurate. To request an amendment, you must submit a written request containing your name, contact information, and a reason supporting your request for amendment to our Privacy Officer Sharon Williams. Our practice reserves the right to deny your request if the following are true:

- A.) Your request was not complete or not submitted in writing.
- B.) The information you wish to amend is deemed accurate or complete by our practices based on our professionals’ observation or knowledge.
- C.) The information you wish to amend is not part of the personal health information recorded by our practices.

\* Information not recorded by our practices may be amended if the individual or entity that originally recorded the information is unable to amend the information personally.

**Authorization for Additional Uses and Disclosures:** As a patient, you have the right to agree to additional disclosures of your personal health information not detailed in this notice but permissible by applicable law. Our practices will obtain express written permission from you for any additional disclosures. You also have a right to revoke any permission you grant by submitting a written request to our Privacy Officer, at which time our practices will cease to disclose your personal health information for the reasons described in your authorization.

**Confidential Communication:** As a patient, you have the right to request that our practices communicate information regarding your plan of care and personal health information in a particular manner (i.e. - contacting you only at home instead of work.) In order to request a plan for confidential communication, you must submit a written request containing your name, contact information, and directions for your preferred method/ location of contact to our Privacy Officer. Our practice will accommodate **reasonable** requests submitted according to the directions above.

**Copies and Inspections:** As a patient, you have the right to obtain and inspect a copy of the personal health information used to make decisions regarding you and your care. This information may include medical and financial billing records, but does **not** include any psychotherapy notes. In order to obtain a copy of your health information, you must submit a written request containing your name and contact

information to our Privacy Officer. Our practices reserve the right to charge a fee for the costs associated with copying and mailing your request. Additionally, our practices reserve the right to deny your inspection or copy request if certain circumstances exist. However, if your request is denied, you are entitled to view a report stating the reasons for our denial.

**Restriction Requests:** As a patient, you have the right to request a restriction of the personal health information we disclose regarding your treatment, payment, or health care operations. To obtain such a restriction, submit a written request containing your name, contact information, the information you wish to be restricted, and the capacity of the restriction to our Privacy Officer.

**Right to File a Complaint:** As a patient, you may file a **written** complaint with our Privacy Officer Sharon Williams or the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be penalized for filing a complaint.

**Right to a Paper Copy of This Notice:** As a patient, you are entitled to a paper copy of this notice detailing the privacy practices of Dermatology Associates of Atlanta, P.C., the Surgical Suite, and all of its divisions listed above. You may request said copy at any point by submitting a request to our Privacy Officer.

#### **Privacy Officer Contact**

If you have any additional questions regarding the privacy practices detailed in this notice or wish to submit any of the requests detailed above, please contact:

**Sharon Williams, Privacy Officer**

**(404) 256-4457**