

**NOTICE OF PRIVACY PRACTICES**  
**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.**

**Your Health Information – Protecting Your Privacy**

It is your right as a patient to be informed of the privacy practices of your health care provider and your rights to your personal health information. This document is intended to provide you with this information.

**Comprehensive Pain Management of the Fox Valley's Responsibilities**

It is your right as a patient to be informed of the legal duties of Comprehensive Pain Management (CPM) to protect the privacy of your health information.

CPM is required to:

- Maintain the privacy of your health information;
- Provide you with a notice of the legal duties and privacy practices regarding health information;
- Abide by the terms of this notice.

CPM reserves the right to change the terms of the notice of privacy. CPM will promptly revise and distribute its notice whenever a substantial change is made to any of its privacy practices.

CPM will not use or disclose your health information without your authorization, except as described in this notice.

**Your Health Information Rights**

**You have the right to:**

- **Request a restriction on certain uses and disclosures of your health information.** You have the right to request restrictions. However, Comprehensive Pain Management (CPM) is not required to agree to your requested restriction. For example, an employee of a clinic receiving health care services in the clinic may request their health care record not be maintained in the general record filing area.
- **Receive confidential communications.** You have the right to request that CPM communicate your health information to you by alternative means or at alternative locations. CPM will accommodate reasonable requests.
- **Inspect and obtain a copy of your health record.** You have the right to inspect and obtain a copy of your health care record. Submit requests in writing. CPM may charge a reasonable fee for copying your health care record.
- **Amend your health record.** You have the right to request an amendment to your health care record if you believe it is incorrect or incomplete. Submit requests in writing stating the reason for record change. If CPM did not create the health information you believe to be incorrect or if CPM disagrees with you, your request may be denied.

- **Obtain an accounting of disclosures of your health information.** You have the right to an accounting of disclosures of your health information that CPM has made. The accounting will describe the dates of each disclosure, a brief description of information disclosed and the reason for disclosure. You may receive one accounting per year at no charge. CPM may charge a reasonable fee for additional requests.
- **Obtain a paper copy of the notice.** You have the right to obtain a copy of this notice at any time upon request.

## **Uses and Disclosures for Treatment, Payment, and Health Care Operations**

**Comprehensive Pain Management (CPM)** is permitted to use or disclose your protected health information for treatment, payment, or health care operations.

**CPM may use or disclose your health information for treatment.** Example: Your information may be disclosed from one physician to another when consulting on your care.

**CPM may use or disclose your health information for payment.** This may include information that identifies you, your diagnosis, and treatment. Example: CPM may use or disclose your information to your insurer to obtain payment for health care services.

**CPM may use or disclose your health information for routine health care operations.** This includes evaluation of provider performance and care given, activities relating to compliance with the law, and business development.

**Appointment Reminders:** CPM may use your health information to provide you with appointment reminders.

## **Uses or Disclosures of Your Protected Health Information Permitted Without Your Authorization**

Without your written authorization, CPM may use or disclose your health information for the following purposes:

**As required by law:** CPM may disclose your health information for the following purposes:

- Disclosures about victims of elderly or child abuse;
- Disclosures for judicial and administrative proceedings; or
- Disclosures for law enforcement purposes.

**Public health:** As required by law, CPM may disclose information to the State of Wisconsin for statutory reporting.

CPM may disclose your protected health information to a state or federal public health agency for the purpose of preventing or controlling disease, injury, or disability.

**CPM** may disclose your protected health information without authorization to the Food and Drug Administration (FDA).

**CPM** may disclose your protected health information for a work related injury when workers' compensation has been filed.

**Victims of abuse, neglect or domestic violence:** **CPM** may disclose your health information if **CPM** reasonably believes that an individual is a victim of abuse.

**Judicial and administrative proceedings:** **CPM** may disclose your protected health information in response to a court order or subpoena, or in response from a state or federal agency.

**Law enforcement:** **CPM** may disclose information to law enforcement officials for the reporting/investigation of abuse.

**For activities related to death:**

**Coroner or medical examiner:** **CPM** may disclose your protected health information to a coroner/medical examiner.

**Research:** **CPM** may use or disclose information for research purposes if the researcher has obtained your permission or fulfilled the stringent privacy requirements of state and federal law.

**Workers compensation:** **CPM** may disclose health information reasonably related to a worker's compensation injury.

Except for the situation listed above, treatment, payment or health care operation, the use or disclosure of your information requires **CPM** to obtain your written authorization. Authorization may be withdrawn in writing to **CPM**.

### **Patient Complaint Process**

If you believe your privacy rights have been violated, you may file a complaint with **CPM** or with the Secretary of the Department of Health and Human Services. There will be no retaliation against you for filing a complaint.

To file a complaint with **CPM** please contact the Privacy Officer who will provide you with the necessary assistance.

### **Questions or Concerns**

If you have any questions or concerns regarding your privacy rights or this notice, please contact Connie Rickert at:

Comprehensive Pain Management of the Fox Valley, SC  
820 East Grant Street Suite S335  
Appleton, WI 54911  
(920) 733-7230 or (877) 733-7230

**COMPREHENSIVE PAIN MANAGEMENT OF THE FOX VALLEY  
WRITTEN ACKNOWLEDGEMENT OF RECEIPT**

I, \_\_\_\_\_, acknowledge that I have received the written Notice of Privacy Practices from Comprehensive Pain Management of the Fox Valley.

\_\_\_\_\_  
Patient or Personal Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
If Personal Representative, describe relationship

\_\_\_\_\_ The patient's condition prohibits the individual from signing an acknowledgement at this time.

It will be obtained as reasonably practicable after the patient's condition improves.

\_\_\_\_\_ Acknowledgement was unable to be obtained.

Reason: \_\_\_\_\_

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

**Disclosure of Private Patient Information**

The following person(s) may receive private patient information without my written or verbal consent:

1. \_\_\_\_\_  
Name Relationship Birthdate

2. \_\_\_\_\_  
Name Relationship Birthdate

I hereby consent for Comprehensive Pain Management Of The Fox Valley to leave a message at my:

\_\_\_\_\_ Home \_\_\_\_\_ Work  
\_\_\_\_\_ Cell: ( ) \_\_\_\_\_ Other: ( ) \_\_\_\_\_

\_\_\_\_\_ This authorization expires on \_\_\_\_\_ (Date)

\_\_\_\_\_ This authorization does NOT expire \_\_\_\_\_ (Patient's Initials)

**Please be advised that if any of the above information is not complete in nature, private patient information will be released ONLY to the patient.**

\_\_\_\_\_  
Patient or Personal Representative Signature

\_\_\_\_\_  
Date