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.

The Toledo Clinic Inc.'s Notice of Privacy Practices for Protected Health Information

I. Uses and Disclosures of Your Medical Information.

A. Treatment, Payment, and Operations. The Toledo Clinic, Inc. (sometimes referred to as "we" or "us") is permitted to use your medical information for purposes of treating you, to obtain payment for providing medical services to you, and to assist in its health care operations. We may also use your medical records to assess the appropriateness and quality of care that you received, improve the quality of health care, and achieve better patient outcomes. An understanding of what is in your health records and how your health information is used helps you: ensure its accuracy and completeness; understand who, what, where, why, and how others may access your health information; and make informed decisions about authorizing disclosures to others.

(i) Use of your protected health information for treatment purposes. A physician or another member of your health care team will record information in your record to diagnose your condition and determine the best course of treatment for you. We will also provide your primary physician, other health care professionals, or a subsequent health care provider, copies of your records to assist them in treating you.

(ii) Use and disclosure of your protected health information for purposes of payment. We may send a bill to you or to a third-party payer, such as a health insurer. The information on or accompanying the bill may include information that identifies you, your diagnosis, treatment received, and supplies used.

(iii) Use and disclosure of your protected health information for healthcare operations. Health care operations consist of activities that are necessary to carry out our operations as a healthcare provider, such as quality assessment and improvement activities. For example, members of our medical staff, the risk or quality improvement manager, or members of the quality assurance team may use information in your health record to assess the care and outcomes in your cases and the competence of the caregivers. We will use this information in an effort to continually improve the quality and effectiveness of the health care and services that we provide.

B. Appointment Reminders and Information about Treatment Alternatives. We may contact you at home to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

C. Other purposes for which we can use your protected health information without written authorization from you. In addition to using your protected health information for purposes of treatment, payment, and health care operations, we may use or disclose your protected health information without your written authorization and without giving you an opportunity to object in the following situations:

(i) As Required by Law. We may use or disclose your protected health information as required by law. We will limit the disclosure to those portions relevant to the requirements of the law.

(ii) Public Health Activities. We may use or disclose your protected health information to public health entities authorized to collect information for the purposes of controlling or preventing disease (including sexually transmitted diseases), injury, or disability. We may also disclose to governmental agencies authorized to receive reports of child abuse or neglect. We may disclose protected health information to the Food and Drug Administration relative to adverse effects/events with respect to food, drugs, supplements, product or product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacement.

(iii) Medical Surveillance of the Workplace and Work-related Injuries. We may provide your protected health information to your employer if we are asked by your employer to provide medical services to you for purposes of medical surveillance of the workplace or a work-related illness or injury.

(iv) Victims of Abuse, Neglect, or Domestic Violence. To the extent authorized or required by law, and in the exercise of our doctor's professional judgment, we believe the disclosure is necessary to prevent harm, we may disclose protected health information to law enforcement officials.

(v) Health Oversight Activities. We may disclose your protected health information to a governmental health oversight agency overseeing the health care system, governmental benefit programs, or compliance with governmental program standards.

(vi) Judicial and Administrative Proceedings. We may disclose your protected health information in response to an order of a court or a valid subpoena.

(vii) Law Enforcement Purposes. We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena or we may provide limited information for identification or location purposes.

(viii) Information About Deceased Individuals. We may disclose your protected health information to coroners and medical examiners to carry out their official duties, and to funeral directors as necessary to carry out their duties to the deceased individual.

(ix) Organ, Eye, or Tissue Donation. We may disclose protected health information to organ procurement agencies for the purpose of facilitating organ, eye, or tissue donation or transplantation.

(x) Research Purposes. We may disclose protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

(xi) Avoidance of Serious Threat to Health or Safety. We may disclose protected health information if we believe in good faith that such disclosure is necessary to prevent or lessen a serious and immediate threat to health and safety of a person or the public.

(xii) Certain Specialized Governmental Functions. If you are Armed Forces or foreign military personnel, we may disclose your protected health information to your appropriate military command. We may disclose your protected health information to a governmental agency as authorized by the National Security Act or for the protection of the President of the United States, as required by law.

(xiii) Correctional Institutions. If you are an inmate, we may disclose your protected health information to the correctional institution or law enforcement in the course of providing care to you or the health and safety of others responsible for your custody or other inmates.

(xiv) Disclosures for Workers' Compensation. We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

D. Other uses and disclosures of your protected health information will only be made with your prior written authorization. You may revoke an authorization at any time, provided you do so in writing. We will honor such a revocation except to the extent that we had already taken action in reliance upon your prior authorization.

II. Your Individual Rights. You have the following rights under federal law with respect to your protected health information and may exercise them in the following manner:

A. The Right to Request Restrictions on the Use of Protected Health Information. You have the right to request that we restrict the use of your protected health information. You have the right to request that we limit our disclosure of your protected health information to treatment, payment, and healthcare operations and disclosures to individuals (family members) involved in your care. Such a restriction, if agreed to by us, will not prevent permitted or required uses and disclosures of protected health information. We are not required to agree to any requested restriction.

B. The Right to Receive Confidential Communications of Protected Health Information by Alternative Means. We must accommodate a reasonable written request by you to receive communications of your protected health information by alternative means (e.g., via e-mail) or at an alternative location (e.g., at your place of employment rather than at home).

C. The Right to Inspect and Copy your Medical Records. You have the right to inspect and obtain a copy from us of your protected health information in our possession. We may impose a reasonable cost-based fee for copying your medical records.

D. The Right to Amend Protected Health Information. You have the right to have us amend protected health information in our possession. You must make the request in writing and provide supporting reason(s) for the requested amendment. If we grant the request, we will notify you, and we will make the correction and distribute the correction to those who need it and those whom you identify to us that you want to receive the corrected information.

E. The Right to Receive an Accounting of Disclosures of Protected Health Information. You have the right to obtain an accounting of disclosures by us of your protected health information made on or after April 14, 2003 other than for treatment, payment, and health care operations. The first accounting in any 12-month period is free. Thereafter, we reserve the right to charge a reasonable, cost-based fee.

F. The Right to Obtain a Paper copy of this Notice Upon Request. You have the right to receive a paper copy of this Notice upon request.

III. Our Duties to Safeguard Your Protected Health Information.

A. Our Duties to You. We are required by federal law to maintain the privacy of protected health information and to provide you with notice of its legal duties and privacy practices with respect to your protected health information. We will maintain the privacy of your health information, including implementing reasonable and appropriate physical, administrative, and technical safeguards to protect the information. We have the duty to mitigate any breach of privacy regarding your protected health information.

B. Privacy Notice. The Toledo Clinic is required to abide by the terms of its Privacy Notice as currently in effect.

C. Complaints. You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may obtain and file a Patient Privacy Complaint with our Privacy Officer. You will not be retaliated against for filing a complaint.

D. Contact Person and Telephone Number. If you have questions and/or would like additional information, you may contact Toledo Clinic's Privacy Officer at 419-473-3561.

E. Red Flag Rules. The Toledo Clinic abides by The Fair and Accurate Credit Transaction Act of 2003, Fair Credit Reporting Act (FCRA, 15 U.S.C. 1681 et seq.) and FACTA. (Pub. L. 108-159, 111 Stat. 1952) for the prevention of identity theft.

F. Effective Date. This Privacy Notice is effective April 14, 2003. Revised July 6, 2009

WE RESERVE THE RIGHT TO CHANGE THE TERMS OF OUR NOTICE OF PRIVACY PRACTICES AND TO MAKE THE NEW NOTICE PROVISIONS EFFECTIVE FOR ALL PROTECTED HEALTH INFORMATION THAT WE MAINTAIN. IF WE CHANGE OUR INFORMATION PRACTICES, WE WILL POST THE REVISED NOTICE IN THE OFFICE AND PROVIDE YOU WITH A COPY UPON REQUEST.

ACKNOWLEDGMENT OF RECEIPT OF TOLEDO CLINIC'S NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I acknowledge that I have received Toledo Clinic's Notice of Privacy Practices effective April 14, 2003.

Staff Use Only

PATIENT CHART NUMBER _____

_____
Signature of Patient

_____
Printed Name of Patient

_____
Date of Birth

_____
Signature of Parent/Guardian of Minor

_____
Date

Staff use Only

Good Faith Effort to Obtain Acknowledgment

The above named patient refused to sign the acknowledgment after being requested to do so.

_____
Staff Member Signature

Date: _____

PERSONS THAT ARE ALLOWED TO GIVE/RECEIVE MY PRIVATE HEALTH INFORMATION

METHOD OF ALLOWED RELEASE: _____VERBAL _____WRITTEN

Name	Relationship	Phone #
Name	Relationship	Phone #
Name	Relationship	Phone #

TOLEDO CLINIC
4235 Secor Road
Toledo, Ohio 43623

Billing Policy

All outpatient visits should be paid on the day of the visit. I understand that I am responsible for full payment of all charges for medical services rendered by Toledo Clinic, Inc. physician(s) regardless of insurance coverage, unless a contractual agreement exists with my insurance carrier or my physician.

Signature on File

I hereby authorize the Toledo Clinic, Inc. to submit to my insurance plan all covered services rendered by the physician(s) and to furnish complete information (including Medical Records, if necessary) to my plan regarding services rendered. I understand that in signing this form, the Clinic will not release to anyone, including those processing my Clinic claim, any information that the law specifically protects and for which a special consent is required. For those records to be released, I will need to sign a separate consent. I authorize and direct my insurance carrier to issue payment check(s) directly to the physician(s) rendering covered services unless otherwise notified.

Authorization Signature

I have read this form or had it read to me. I understand it.

_____ _____

Signature of Patient/Authorized Representative **Relationship (if other than patient)**

Patient Name
Chart #

Date:_____