

Washington Center for Weight Management & Research, Inc.

2300 Wilson Blvd., Suite 230

Arlington, VA 22201

Phone: 703-807-0037 Fax 703-807-0038 [www.wtmgmt.com](http://www.wtmgmt.com)

**Notice of Privacy Practices/ Health Information Authorization**

**THIS NOTICE DESCRIBES HOW PROTECTED MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This Notice is first in effect on July 24, 2008.

This notice covers all information in our written or electronic records which concerns you, your health care, and payments for your health care. It also covers information we may have shared with other organizations to help us provide your care, get paid for providing care or manage some of our administrative operations.

The Washington Center for Weight Management & Research, Inc. (WCWMR) physicians and staff may use and disclose medical information (protected health information or PHI) about an individual for:

1. Medical Treatment- i.e.; providing medical care services, sending/coordinates medical care information with other health care providers caring for you, ordering and obtaining off site test results, writing prescriptions, etc.
2. Research study participation-i.e.; sending/coordination of medical care information with other health care providers caring for you in regards to safety during and prior to participation in a research protocol, etc.
3. Payment-i.e., preparing or submitting insurance claims on your behalf for treatment rendered.
4. Health care operations- i.e., internal business planning activities and quality of care evaluation.

The WCWMR is permitted or required under specific circumstances, to use or disclose protected health information without the individual's written authorization, including, but not limited to:

1. Disclosures required by law
2. Disclosures to avert serious threats to health or safety
3. Disclosures with reference to workers' compensation or Food and Drug Administration (FDA)

Other uses and disclosures will be made only with the individual's written authorization, and the individual may revoke such authorization. (Please see below for identifying persons to whom you would allow disclosures of otherwise protected information.)

The WCWMR may contact the individual to provide appointment reminders or information about treatment or other health-related benefits and services that may be of interest to the individual or patient. WCWMR will routinely contact patients via telephone at home and/or work and, unless otherwise requested, may leave messages on the appropriate voice mail or answering service regarding appointments, test results, etc. We may also send faxes or email, if you have designated this option.

Our patients have the following rights regarding their protected health information:

1. The right to request restrictions on certain uses and disclosures of PHI. WCWMR is not required to agree to a certain restriction, however.
2. The right to inspect and copy PHI, as provided in the Privacy Regulation.
3. The right to receive confidential communications of PHI, as applicable.
4. The right to amend PHI, as provided in the Privacy Regulation.
5. The right to receive an accounting of disclosures of PHI.
6. The right to obtain a paper copy of this Notice from the covered entity upon request. This right extends to an individual who has agreed to receive the Notice electronically.

WCWMR is required by law to maintain the privacy of PHI and to provide individuals with notice of its legal duties and privacy practices with respect to PHI. WCWMR is required to abide by the terms of the Notice currently in effect.

WCWMR reserves the right to change the terms of this Notice. The new Notice provisions will be effective for all PHI that it maintains. WCWMR will provide individuals or patients with a revised Notice by posting new regulations in the office.

Individuals may complain to WCWMR and the Secretary of the Department of Health and Human Services, without fear of retaliation by the organization, if they believe their privacy rights have been violated. WCWMR's contact person for matters relating to complaints is:

Michelle Vaughan, MBA- the WCWMR Privacy Official

2300 Wilson Blvd., Suite 230

Arlington, VA 22201

Phone: 703-807-0037, ext. 109 Fax 703-807-0038

[michellevaughan.mba@gmail.com](mailto:michellevaughan.mba@gmail.com)

Please provide the name(s) of person(s) if any, to whom you would *permit* the Washington Center for Weight Management & Research, Inc. (WCWMR) to disclose personal health information as necessary for our continued health care. Please also note if specific health care information cannot be disclosed (i.e., test results, appointment information, etc.) Otherwise, we will disclose only what is necessary for your continued health care in accordance to this Privacy Policy.

List below those individuals (family, friends, etc.) you will *allow* disclosure of your personal health information from WCWMR as necessary during the course of your health care services:

Spouse/Significant Other: \_\_\_\_\_

All  Specify \_\_\_\_\_

Family  Friend Name: \_\_\_\_\_

All  Specify \_\_\_\_\_

Family  Friend Name: \_\_\_\_\_

All  Specify \_\_\_\_\_

\_\_\_\_\_ Initial if you will allow interpreter services if necessary for communication with health care providers.

I acknowledge and understand that the WCWMR's policy is to send copies of test results and/or other medical information to physicians who either ordered the procedure/consult or are in need of this health information to ensure coordinated and effective diagnosis/treatment, i.e., your designated primary care provider or physicians seen for consult/treatment. WCWMR's policy is to only disclose specific information necessary for coordination of your health care, medical treatment or research participation.

Signature

Date

List below physician providers who you **DO NOT** want specified PHI sent which could be sent in the usual course of facilitating or coordinating medical treatment or research participation.

Please **DO NOT** send PHI to those listed below:

Provider Name: \_\_\_\_\_

All  Specify \_\_\_\_\_

Provider Name: \_\_\_\_\_

All  Specify \_\_\_\_\_

Provider Name: \_\_\_\_\_

All  Specify \_\_\_\_\_

**(Initial)** I acknowledge and understand WCWMR's policy to contact me by various means when necessary for my health care services that may include my home/work/ cell phone, fax, and/or email. I also understand that private health information may be included in that communication to **me**.

I **DO NOT** want WCWMR to use the following methods of communication which may include my private health information: **(Please Initial ALL you DO NOT want used)**

Home Telephone

Cell Phone

Work Telephone

Fax Machine (if provided)

Email (if provided)

Other (If Other, please specify):

By signing below, I hereby acknowledge that I have read WCWMR's Notice of Privacy Practices and received a copy (if requested).

Signature

Date