

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.

Understanding Your Health Record Information

Each time you visit a healthcare provider, a record of your visit is made. Typically this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a basis for planning your care and treatment and serves as a means of communication among the many healthcare professionals who contribute to your care.

We at Dermatology and Skin Care Associates, P.C. ("DSCA") pledge to provide you with the highest quality of care and to build a relationship with you that is based on trust. This trust includes our commitment to respect the privacy and confidentiality of your health information. This Notice describes the privacy practices of DSCA, its physicians, nurses, and other personnel.

Our Privacy Obligations Federal law gives you the right to be informed in advance about how DSCA will handle your medical information; what our legal duties are in relation to your medical information; what your rights are regarding your medical information; and a method of filing complaints about our privacy policies. We are required by law to maintain the privacy of your medical and health information ("**Protected Health Information**" or "**PHI**") and to provide you with this Notice of our legal duties and privacy practices with respect to your PHI. When we use or disclose your PHI, we are required to abide by the terms of this Notice (or other notice in effect at the time of the use or disclosure).

Permissible Uses and Disclosures The following categories describe different ways that we use and disclose your PHI. Please note that

not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose your PHI without your written Authorization will fall within one of these categories:

We may use and, with your consent, disclose your PHI to provide treatment and other services to you – for example, to diagnose and treat your injury or illness or to disclose PHI to other providers involved in your treatment. In addition, we may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use and, with your consent, disclose PHI to obtain payment for services that we provide to you – for example, to file claims and obtain payment from your health insurer, HMO, or other company that arranges or pays the cost of some or all of your health care ("**Your Payor**") or to verify that Your Payor will pay for health care. In certain circumstances we may disclose PHI to Your Payor without your consent if Your Payor had previously notified you that this disclosure may occur. With your consent, we may also disclose PHI to Your Payor to assist another health care provider obtaining payment for services rendered to you.

We may use and, with your consent, disclose PHI for our health care operations, which include internal administration and planning and various activities that improve the quality and cost effectiveness of the care and customer service that we deliver to you. For example, we may use PHI to evaluate the quality and competence of our physicians, nurses and other health care workers and we may disclose PHI in order to resolve any complaints you may have and ensure that you have a

pleasant visit with us. In certain circumstances, we may disclose PHI without your consent for purposes relating to our peer review and utilization review activities. With your consent, we may disclose PHI to another health care provider in connection with the other health care provider's health care operations.

We may disclose PHI, other than Highly Confidential Information (described below in Section V), to a family member, other relative, a close personal friend, a caregiver, or any other person identified by you when you are present for, or otherwise available prior to, the disclosure, and do not object to such disclosure after being given the opportunity to do so. We may also disclose your PHI to such person with your verbal agreement or written consent.

If you are incapacitated or in an emergency circumstance, we may exercise our professional judgment to determine whether a disclosure is in your best interest. If we disclose information in such circumstances, we would disclose only information that we believe is directly relevant to the person's involvement with your health care or with payment related to your health care. We may also disclose your PHI in order to notify (or assist in notifying) such persons of your location, general condition, or death.

We may disclose your PHI for the following public health activities: to report health information to public health authorities for the purpose of preventing or controlling disease, injury or disability; to report child abuse and neglect, elder abuse, disabled persons abuse, or rape or sexual assault to public health authorities or other government authorities authorized by law to receive such reports; to report information about products and services under the jurisdiction of the U.S. Food and Drug Administration; if we know or have reason to believe that you are infected with a venereal disease, to alert (a) your fiancée, if you are engaged, or your spouse, if you are married, or (b) your parent or guardian if you are a minor, unless as an emancipated minor you have sought treatment with us for such venereal disease; to report information to your insurer and/or the Massachusetts Industrial Accident Board as required under laws addressing work-related illnesses and injuries or work-

place medical surveillance; to report information related to the birth and subsequent health of an infant to state government agencies, as required by law; to file a death certificate and report a fetal death; and to report an abortion performed after 24 weeks of pregnancy to state government agencies, as required by law.

We may disclose PHI to a health oversight agency that oversees the health care system or government benefit programs (such as Medicare or Medicaid). We may use and disclose your PHI to units of the government with special functions, such as the U.S. military or the U.S. Department of State under certain circumstances as required by law. We may disclose your PHI to a coroner or medical examiner as authorized by law. If you are an organ donor, we may disclose your PHI to organizations that facilitate organ, eye or tissue procurement, banking or transplantation.

We may use or disclose your PHI without your consent or authorization for research purposes if an Institutional Review Board/Privacy Board approves a waiver of authorization for such use or disclosure. We can use de-identified information for research purposes without your authorization.

We may use or disclose your PHI for health or safety; to prevent or lessen a serious danger to you or others.

We may disclose your PHI in the course of a judicial or administrative proceeding in response to a legal order, subpoena (under certain circumstances), order of either the Commissioner of Public Health or the Commissioner of Mental Health or other lawful process. We may disclose PHI when required to report findings from an examination ordered by a court or detention facility. We may disclose your PHI to the police or other law enforcement officials as required or permitted by law or in compliance with a court order or a grand jury or administrative subpoena. We may use and disclose your PHI when required to do so by any other law not already referred to in the preceding categories.

Uses and Disclosures Requiring Your Written Authorization For any purpose other than those described in Section III, we may use or

disclose your PHI only when you give us your written authorization on our authorization form (“**Authorization**”). For instance, you will need to provide us your signed Authorization before we can send PHI to your life insurance company, to your child’s camp or school, or to the attorney representing the other party in litigation in which you are involved (unless the attorney has obtained a court order for such PHI).

We must also obtain your written authorization prior to using PHI to send you any marketing materials (“**Marketing Authorization**”). We can, however, provide you with marketing materials in a face-to-face encounter, without obtaining your Marketing Authorization. We are also permitted to give you a promotional gift of nominal value, if we so choose, without obtaining your Marketing Authorization. In addition, we may communicate with you about products or services relating to your treatment, case management or care coordination, or alternative treatments, therapies, providers or care settings without your Marketing Authorization, and we may use PHI to identify health-related services and products that may be beneficial to your health and then contact you about the services and products. Unless you specifically request in writing not to receive any mailings from us, we can send you a written or electronic newsletter or other information about DSCA, including services we offer. A request not to receive information from us should be made in writing to our Privacy Officer. Please note that such a request does not prohibit us from sending you information that is important for your medical care.

Federal and state law require special privacy protections for certain highly confidential information about you (“**Highly Confidential Information**”), including: your HIV/AIDS status; genetic testing information; confidential communications with a psychotherapist, psychologist, social worker, sexual assault counselor, domestic violence counselor, or other allied mental health professional, or human services professional; substance abuse (alcohol or drug) treatment or rehabilitation information; venereal disease information; abortion consent form(s); mammography records; fam-

ily planning services; treatment or diagnosis of emancipated minors; mental health community program records; and research involving controlled substances. In order for us to disclose your Highly Confidential Information for any purpose, we must obtain your separate, specific written consent (or Authorization) unless we are otherwise permitted by law to make such disclosure.

In addition, if you are an emancipated minor, certain information relating to your treatment or diagnosis may be considered “Highly Confidential Information” and, as a result, will not be disclosed to your parent or guardian without your consent (or Authorization). Your consent is not required, however, if a physician reasonably believes your condition to be so serious that your life or limb is endangered. Under such circumstances, we may notify your parent(s) or legal guardian of the condition, and we will inform you of any such notification.

Your Individual Rights If you desire further information about your privacy rights, are concerned that we have violated your privacy rights or disagree with a decision that we made about access to your PHI, you may contact our Privacy Office. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, the Privacy Office will provide you with the correct address for the Director. We will not retaliate against you if you file a complaint with us or the Director.

You may request restrictions on our use and disclosure of your PHI for treatment, payment and health care operations, to individuals (such as a family member, other relative, close personal friend or any other person identified by you) involved with your care or with payment related to your care, or to notify or assist in the notification of such individuals regarding your location and general condition. All requests for such restrictions must be made in writing. While we will consider all requests for additional restrictions carefully, we are not required to agree to a requested restriction. If you wish to request additional restrictions, please obtain a request form from our Privacy

Office and submit the completed form to the Privacy Office. We will send you a written response.

You may request, and we will accommodate, any reasonable written request for you to receive your PHI by alternative means of communication or at alternative locations, such as to receive confidential communications.

You may request access to your medical record file and billing records maintained by us in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, we may deny you access to your records. If you desire access to your records, please obtain a record request form from the Privacy Office and submit the completed form to the Privacy Office. If you request copies, to the extent permitted by law, we will charge you \$0.50 (50 cents) for each page up to 100 pages and \$0.25 (25 cents) thereafter. We will also charge you for our postage costs, if you request that we mail the copies to you. If someone other than you requests copies of your medical records, and we are permitted or authorized to provide a copy of the record, we will charge the same per page cost stated above plus a base charge of \$15.

You may revoke your Authorization, your Marketing Authorization, or any written authorization obtained in connection with your Highly Confidential Information, except to the extent that we have taken action in reliance upon it, by delivering a written revocation statement to the Privacy Office identified below. A form of Written Revocation is available upon request from the Privacy Office.

You have the right to request that we amend Protected Health Information maintained in your medical record file or billing records. If you desire to amend your records, please obtain an amendment request form from the Privacy Office and submit the completed form to the Privacy Office. We will comply with your request unless we believe that the information that would be amended is accurate and complete or other special circumstances apply.

Upon written request, you may obtain an accounting of certain disclosures of your PHI

made by us during any period of time prior to the date of your request, provided that such period does not exceed six years. If you request an accounting more than once during a twelve (12) month period, we will charge you \$1.00 per page of the accounting statement.

Upon request, you may obtain a paper copy of this Notice, even if you have agreed to receive such notice electronically.

Use of Integrated Electronic Medical Record
DSCA participates in an integrated electronic medical record to increase coordination of care among your caregivers at other Partners Health Care System affiliated sites (including but not limited to Newton-Wellesley Hospital, Massachusetts General Hospital, and Brigham and Women's Hospital). Some or all of the medical information you share with us may be entered into this integrated record. Access to the integrated medical record is expressly restricted to those clinicians and staff involved in your care, or to those who need the information for payment or health care operations or other purposes as set forth in this Notice. The privacy obligations of DSCA and your health information rights set forth in this Notice also apply to information maintained in the integrated medical record.

This Notice is effective on January 1, 2008.
We may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all Protected Health Information that we maintain, including any information created or received prior to issuing the new notice. If we change this Notice, we will post the revised notice in waiting areas around DSCA and on our Web Site: www.dermandskincare.com. You also may obtain any revised notice by contacting the Privacy Office. You may contact the Privacy Office at:

Privacy Office
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Wellesley, MA 02481
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