



## NOTICE OF PRIVACY PRACTICES

EFFECTIVE DATE: \_\_01/01/2025

LAST REVISION DATE: \_\_4/7/2026

**THIS NOTICE OF PRIVACY PRACTICES (“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.**

### ABOUT THIS NOTICE

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how Georgia Kidney Associates, our Business Associates, and our Business Associates’ subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO), and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information.

“Protected Health Information” is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health condition and related health care services.

Georgia Kidney Associates is required by the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and other applicable laws to maintain the privacy of your health information, to provide individuals with this Notice of our legal duties and privacy practices with respect to such information, and to abide by the terms of this Notice. We are also required by law to notify affected individuals following a breach of their unsecured health information.

### USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician’s practice, and any other use required by law.

Treatment: Georgia Kidney Associates may use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information will be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information may be used, as needed, to obtain payment for your health care services. For example, obtaining approval for treatment or a hospital stay may require that your relevant protected health information to be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of our physician’s practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students who see patients at our office. We may also call you by name in the waiting room when your

physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under federal law, we are required to disclose your protected health information to you upon request in certain circumstances.

The HIPAA law requires us to also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Data Breach Notification: Notice is required upon discovery or notification of a breach in the security of a system that contains computerized data; notification is required to any resident of Georgia whose unencrypted personal information was, or is reasonably believed to have been, acquired by an unauthorized person.

Notice must be provided in the most expedient time possible and without unreasonable delay, consistent with the needs of law enforcement as provided in Ga. Code Ann. § 10-1-912(c) or with any measures necessary to determine the scope of the breach and restore the reasonable integrity, security and confidentiality of the data system.

## **USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION**

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization, or opportunity to object, unless required by law. Without your authorization, we are expressly prohibited from using or disclosing your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information.

We will not use or disclose your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Carequality Electronic Sharing: I hereby consent to and authorize to share my health data with my other healthcare providers through the Carequality platform. I understand that my health data will only be shared with providers that I have given consent to access my information. This will allow all of my doctors to have access to my updated medical information in an efficient and timely manner. Information that is shared includes: Name, Date of Birth, Address, Office Notes, Labs, and Procedure Results. No financial or Insurance information will be shared or transmitted. This transmission of data is meant to replace the need for manual faxing and I understand that Carequality will transmit my data securely to protect my privacy.

## **YOUR RIGHTS**

The following are statements of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information** – Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. We will provide a copy or a summary of your health information, usually within 30 days of your request.

We may charge a reasonable, cost-based fee. If we deny access to the requested information, you can appeal the denial.

Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

**You have the right to request a restriction of your protected health information** – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

**You have the right to request to receive confidential communications** – You have the right to request confidential communication from us by alternative means or at alternative locations. We will comply with all reasonable requests, but we reserve the right to request the details in writing. We will not require an explanation for the request as a condition of agreeing to follow it. We also have the option to condition the agreement for alternate confidential communications with assurance that payment of special fees required will be handled.

**You have the right to request an amendment to your protected health information** – You have the right to request an amendment to health information about you if you think is incorrect or incomplete. We may deny your request if we did not create the protected health information, if the amendment would not be part of our normal record keeping of protected health information, if the amendment would never be included for inspection by any other group or party or if we believe the record is accurate and complete without the amendment. We will not require an explanation for the request for amendment from you as a condition of agreeing to follow it.

If we deny your request for amendment, we will tell you why in writing within 60 days. You have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of it.

**You have the right to receive an accounting of certain disclosures** – This accounting will not include disclosures made for treatment, payment, or health care operations; disclosures made with your authorization; disclosures required by law; or disclosures made more than six years before the date of your request.

**You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically.** We will also make available copies of our Notice, if you wish to obtain one.

**You have the right to be notified in the event of a breach** – You have the right to receive written notification if we discover a breach of your unsecured protected health information. We will notify you without unreasonable delay and in accordance with federal and applicable state law. The notice will describe what happened, the information involved, what steps you should take to protect yourself, what we are doing to investigate and mitigate the breach, and how you may contact us for additional information.

**We reserve the right to change the terms of this notice and the changes will apply to all information we have about you.** The new notice will be available upon request, in our office, and on our website.

## COMPLAINTS

You may complain to us if you believe your privacy rights have been violated by us. You may reach out to our

Office Manager, Felicia West, by calling our office at 770-427-7389 ext. 212. sending an email to Felicia.West@georgiakidney.com or sending a letter to our office at 55 Whitcher st. ste 460 Marietta, GA 30060. We will not retaliate against you in any way for filing a complaint.

You can also file a complaint with the Secretary of the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, or calling 1-877-696-6775, or by visiting [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/).

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our Office Manager, Felicia West, in person or by phone at 770-427-7389 ext 212.

Please sign the "Acknowledgment" below. By signing this form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have received a copy of Georgia Kidney Associate's "Notice of Privacy Practices" for protected health information on the date set forth below.

\_\_\_\_\_ Date of Receipt

\_\_\_\_\_ Patient Date of Birth

\_\_\_\_\_ Patient Name

\_\_\_\_\_ Authorized Personal Representative

\_\_\_\_\_ Patient Signature

\_\_\_\_\_ Signature of Authorized Personal Representative

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**FOR USE BY GEORGIA KIDNEY ASSOCIATES PERSONNEL ONLY**  
**Complete if patient acknowledgement is not obtained.**

An Acknowledgment of Receipt of Notice of Privacy Practices was not received because:

- \_\_\_\_\_ Patient refused to sign Acknowledgment
- \_\_\_\_\_ Unable to gain signed Acknowledgment due to communication / language or other barrier
- \_\_\_\_\_ Patient was unable to sign Acknowledgment due to emergency treatment situation
- \_\_\_\_\_ Other (please indicate reason):

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Signature of Georgia Kidney Associates Representative

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Date