

NOTICE OF PRIVACY PRACTICES

The State agency is responsible for numerous programs, which deal with medical and other confidential information. Both Federal and State laws establish strict requirements for most programs regarding the disclosure of confidential information, and the Department must comply with those laws. For situations where more stringent disclosure requirements do not apply, this Notice of Privacy Practices describes how the Department may use and disclose your protected health information for treatment, payment, healthcare operations and for certain other purposes.

This notice relates only to health information. It describes your rights to access and control your protected health information, and provides information about your right to make a complaint if you believe the Department has improperly used or disclosed your “protected health information.” Protected health information is information that may personally identify you and relates to your past, present or future physical or mental health or condition and related health care services. The Department is required to abide by the terms of this Notice of Privacy Practices, and may change the terms of this notice, at any time. A new notice will be effective for all protected health information that the Department maintains at the time of issuance. Upon request, the Department will provide you with a revised Notice of Privacy Practice by posting copies at its facilities, publication on the Department’s website, in response to a telephone or facsimile request to the Privacy Coordinator, or in person at any facility where you receive services from the Department.

1. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by the Department, its administrative and clinical staff and other involved in your care and treatment for the purpose

of providing health care services to you, and to assist in obtaining payment of your health care bills.

a. Treatments: Your protected health information may be used to provide, coordinate, or manage your health care and any related services, including coordination of your health care with a third party that has your permission to have access to your protected health information, such as, for example, a health care professional who may be treating you, or to another health care provider such as a specialist or laboratory.

b. Payment: Your protected health information may be used to obtain payment for your health care services. For example, this may include activities that health insurance plan requires before it approves or pays for health care such as; making a determination of eligibility or coverage, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

c. Health Care Operations: The Department may use or disclose your protected health information to support the business activities of the Department, including, for example, but not limited to, quality assessment activities, employee review activities, training, licensing, and other business activities. The Department may use a sign-in sheet at the registration desk at any facility where services are called by name in the waiting room what a staff member is ready to see you, and your protected health information may be used to contact you about appointments or for other operational reasons. your protected health information may be shared with third party “business associates” who perform various activities that assist us in the provision of your services. Other uses and disclosures of your protected health information will be made only with your written authorization, which you may revoke in writing at any time, except as permitted or required by law as describe below.

2. Other Permitted or Required Uses and Disclosures with Your Authorization or Opportunity to Object

Other uses and disclose your protected health information in the following instances. You have the opportunity to:

agree or object to the use or disclosure of all or part of your protected health information unless you object, the Department may disclose protected health information for a facility directory or to a family member, relative, or any other person you identify, information related to that person’s involvement in your health care and may use or disclose protected health information to notify or assist in notifying a family member, personal representative or other

person responsible for your care of your location, general condition or death. The Department may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other Residents involved in your health care. Objections may be made orally or in writing.

3. Permitted or Required Uses and Disclosures without Your Authorization or Opportunity to Object

The Department may use or disclose your protected health information without your authorization when required to do so by law; for public health purposes; to a person who may be at risk of contracting a communicable disease to a health oversight agency; to an authority authorized to receive reports of abuse or neglect; in certain legal proceedings; and for certain law enforcement purposes. Protected health information may also be disclosed without your authorization to a coroner, medical examiner or funeral director; for certain approved research purposes; to prevent o lesson a threat to health or safety; and to law enforcement authorities for identification or apprehension of a Resident.

4. Required Uses and Disclosures: Under the law, the Department must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine the Department’s compliance with the requirements of the Privacy Rule at 45 CPR Sections 164.500 et. seq.

5. Your Rights: The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

a. You have the right to inspect and copy your protected health information. Upon written requests, you may inspect and obtain a copy of protected health information about you for as long as the Department maintains the protected health information. This information includes medical and billing records and other records the Department uses for making medical and other decisions about you. A reasonable, cost-based fee for copying, postage and labor expense may apply. Under federal law you may not inspect or copy information compiled in anticipation of, or for use in, a civil, criminal, or administrative proceeding, or protected health information that is subject to a federal or state law prohibiting access to such information.

b. You have the right to request restriction of your protected health information. You may ask in writing that the Department not use or disclose any part of your protected health information for the purposes of treatment, payment or health operations, and not to

disclose protected health information to family members or friends who may be involved in your care. Such a request must state the specific restriction requested and to whom you want the restriction to apply. The Department is not required to agree to a restriction ou request, and if the Department believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted, except as required by law. If the Department does agree to the requested restriction, the Department may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment.

c. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. Upon written request, the Department will accommodate reasonable requests for alternative means for the communication of confidential information, but may condition this accommodation upon your provision of an alternative address or other method of contract. The Department will not request an explanation from you as to the basis for the request.

d. You may have the right to request amendment of your protected health information. If the Department created your protected health information, ou may request in writing an amendment of that information for as long as it is maintained by the Department. The Department may deny your request for an amendment, and if it does so will provide information as to any further rights you may have with respect to such denial.

e. You have the right to receive an accounting of certain disclosures the Department has made of your protected health information. This right applies only to disclosure for purposes other than treatment, payment of healthcare operations, excluding any disclosures the Department made to you, to family members or friends involved in your care, or for national security, intelligence or notification purposes. Upon written request, you have the right to receive legally specified information regarding disclosures, subject to certain exceptions, restrictions and limitations.

f. You have the right obtain a paper copy of this notice from the Department, upon request.

All written requests regarding your rights as set forth above should be sent to the Privacy Coordinator, Office or facility which maintains PHI.

6. Complaints: You may complain to us and the United States Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint in writing with the facility which maintains your protected health information. You

must state the basis for your complaint. The Department will not retaliate against you for filing a complaint. You may also contact the Division's Privacy Coordinator and the Secretary of Health and Human Services if you believe your health information privacy rights have been violated.

You must state the basis for your complaint. The Department will not retaliate against you for filing a complaint.

ACCEPTANCE:

I, _____ do hereby acknowledge and accept the contents of this policy.

_____ _____

Staff Signature Date