



NOTICE OF PRIVACY PRACTICES

This notice, published April 14, 2003, describes how personal and medical information about you may be used and disclosed, and how you can gain access to this information.

PLEASE READ IT CAREFULLY.

Protected Health Information (PHI) is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information that may identify you and relates to your past, present or future physical or mental health conditions and related healthcare services.

The healthcare providers and staff of Community Health Services (CHS) are required to follow specific rules on maintaining the confidentiality of your PHI, using your information and disclosure or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. This Notice also acknowledges our responsibility and legal obligation to protect your personal and medical information, and describes your rights concerning our use of that information.

YOUR RIGHTS UNDER THE HIPAA PRIVACY RULE

The following is a list of your rights, under the HIPAA Privacy Rule, in reference to your PHI.

- 1. You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices.** We are required to follow the terms of this Notice. We reserve the right to change the terms of this Notice at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices. The Notice is posted on our website.
- 2. You have the right to authorize other use and disclosure of your PHI that is not specified in this Notice.** We would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes or if we intended to sell your PHI. You may revoke this authorization at any time, in writing.
- 3. You have the right to request an alternate means of confidential communication.** You have the right to ask us to contact you about your health information using an alternate method (email, phone) and to an alternate destination (cell phone, alternate address) designated by you. You must inform us of this request in writing on a form provided by our organization. We will follow all reasonable requests.
- 4. You have the right to inspect and receive a copy of your PHI.** You may review and obtain a copy of your complete health record. We have the right to charge a fee for paper or electronic copies of health records as established by state or federal guidelines.

- 5. You have the right to request an amendment to your PHI.** You may request an amendment to your PHI as long as the health record is maintained by our organization. In certain cases, we may deny your request.
- 6. You have the right to request a restriction to your PHI.** You may request a restriction, in writing, not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. If accepted, we will enforce the restriction except in emergency situations when the information is needed for your treatment. In certain cases, we may deny your request. You may request, in writing, that we restrict communication with your health plan for treatment or services that have been paid for in full, out of pocket. We are not permitted to deny this type of requested restriction.
- 7. You have the right to request disclosure accountability.** You may request a list of disclosures that we have made of your PHI to persons or entities outside our organization.
- 8. You have the right to receive a privacy breach notice.** You have the right to receive written notification if our organization discovers a privacy breach of your PHI and determines through a risk assessment that notification is required. You will be notified of the breach as soon as possible, but no later than 60 days after the breach was discovered.
- 9. You have the right to a personal representative.** You may designate a person that has the authority to consent to or authorize the use or disclosure of your PHI (Limited Patient Authorization Form).

HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI)

The following is a list of ways we may use or disclose your PHI that does not require written authorization.

- 1. Treatment.** We may use or disclose your PHI to provide, coordinate or manage your healthcare and any related services. This includes the coordination and management of your healthcare with a third party that is involved in care and treatment. This would also include the pharmacy that would fill your prescriptions and any other healthcare providers that may be involved in your care and treatment.
- 2. Payment.** Your PHI will be used, as needed, to determine eligibility or coverage for insurance benefits and to obtain payments for your healthcare services.

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3. **Healthcare Operations.** We may use or disclose your PHI, as needed, to support the business activities of our organization. This may include, but is not limited to, business planning and development, quality assessment and improvement, medical reviews, legal services, auditing functions and patient safety activities.
4. **Special Notices.** We may use your PHI, as necessary, to contact you by phone or other means, including our patient portal, to remind you of your appointments, to provide you with lab results or results of other diagnostic testing or to provide information that describes or recommends treatment plans or alternatives regarding your care. We may also contact you to provide information about health related benefits and services offered by our organization, fund raising activities or to disclose information regarding a group health plan. You have the right to opt out of such special notices.
5. **Health Information Organization.** The organization may choose to use a health information organization to facilitate the electronic exchange of information for the purposes of treatment, payment or healthcare operations.
6. **To Others Involved in Your Healthcare.** We may disclose your PHI to a family member, friend or any other person that you identify when the information is directly relevant to the person's involvement to the individual's care or payment for that care. If you are not present, unable to agree or object to such a disclosure, we may disclose the necessary information we determine is in your best interest based on our professional judgment. We may use your PHI to notify or assist in notifying a family member, personal representative or other responsible party of your location, general condition or death. Only PHI that is necessary will be disclosed.
7. **Other Permitted and Required Uses and Disclosers.** We are also permitted to use or disclose your PHI without your written authorization for the following purposes:
 - **As required by law** (any information limited to the relevant requirements of the law)

- **For public health activities** (disease control, vital statistics, public health)
- **Health oversight activities** (audits, civil, criminal or administrative investigations)
- **To report cases of abuse, neglect or domestic violence**
- **To comply with Food and Drug Administration requirements**
- **Research purposes**
- **Judicial and administrative proceedings** (in response to a court order)
- **Law enforcement purposes**
- **To coroners, medical examiners and funeral directors** (identifying disease process or cause of death)
- **For organ or tissue donation** (consistent with applicable laws)
- **Specialized government functions** (with regards to military personnel, veterans, national security purposes or when an inmate in a correctional facility)
- **Worker's compensation** (to the extent necessary to comply with applicable laws)
- **To avert serious threats to health or safety**
- **If requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule**

Complaints: If you feel we have violated your privacy rights, or have questions concerning our Notice of Privacy Practices, you may contact or file a written complaint to the following address: **Privacy Officer, Community Health Services, 2221 Hayes Avenue, Fremont, Ohio 43420** or with the federal agency in charge of enforcing patient's privacy rights. That address is: **Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHS Building, Washington D.C. 20201.** We will not retaliate against you for filing a complaint.

This authorization will expire at the end of the calendar year in which it was signed.

PATIENT NAME (PLEASE PRINT)	____/____/____
SIGNATURE OF: <input type="checkbox"/> Patient <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Caregiver	____/____/____
	DATE OF BIRTH
	TODAY'S DATE