

Notice of Health Information Practices

Understanding Your Health Record/Information

Each time you visit a hospital, physician, or other 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
- * means of communication among the many health professionals who contribute to your care
- * legal document describing the care you received
- * means by which you or a third-party payer can verify that services billed were actually provided
- * a tool in educating health professionals
- * a source of data for medical research
- * a source of information for public health officials charged with improving the health of the nation
- * a source of data for facility planning and marketing
- * a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve
- * understanding of what is in your record and how your health information is used to help you to:
 - * ensure its accuracy
 - * better understand who, what, when, where, and why others may access your health information
 - * make more informed decisions when authorizing disclosure to others

Your Health Information Rights

Although your health record is the physical property of the health care practitioner or facility that compiled it, the information belongs to you. You have the right to:

- * request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- * obtain a paper copy of the notice of information practices upon request
- * inspect and copy your health record as provided for in 45 CFR 164.524
- * amend your health record as provided in 45 CFR 164.528
- * obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- * request communications of your health information by alternative means or at alternative locations
- * revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities

This organization is required to:

- * maintain the privacy of your health information
- * provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- * abide by the terms of this notice
- * notify you if we are unable to agree to a requested restriction
- * accommodate reasonable requests you may have to communicate health information by alternative means or alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us.

We will not use or disclose your health information without your authorization, except as described in this notice.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the office manager at 904-278-6663.

If you believe your privacy rights have been violated, you can file a complaint with the director of health information management or with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

Examples of Disclosures for Treatment, Payment, and Health Operations

We will use your health information for treatment.

For example: Information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you're discharged from this hospital (if applicable).

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and service we provide.

Business Associates: There are some services provided in our organization through contacts with Business Associates. Examples include diagnostic services, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our Business Associates so that it can perform the job we've asked it to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

**Consent to the Use and Disclosure of Health Information
for Treatment, Payment, or Healthcare Operations**

I, _____ understand that as part of my healthcare, this practice
(Patient's Name)
originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- * A basis for planning my care and treatment
- * A means of communication among the many health professionals who contribute to my care
- * A source of information for applying my diagnosis and surgical information to my bill
- * A means by which a third-party payer can verify that services billed were actually provided, and
- * A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Health Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change its notice and practices and, prior to implementation, will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

I wish to have the following restrictions to the use or disclosure of my health information:

I fully understand and accept / decline the terms of this consent.

[SIGNATURE]

[DATE]

[WITNESS]

[DATE]