Consent for Service and Financial Responsibility and Notice of Privacy Practices
2225 Keith Parkway, Findlay, Ohio 45840
419-424-7441 option 2

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.

Personally identifiable information about your health, your health care, and your payment for health care is called Protected Health Information. We must safeguard your Protected Health Information and give you this Notice about our privacy practices that explains how, when and why we may use or disclose your Protected Health Information. Except in the situations set out in the Notice, we must use or disclose only the minimum necessary Protected Health Information to carry out the use or disclosure.

We must follow the practices described in this Notice, but we can change our privacy practices and the terms of this Notice at any time.

You also may ask for a copy of the Notice by calling us at 419-424-7105 and asking us to mail you a copy or by asking for a copy at your next appointment.

Uses and Disclosures of Your Protected Health Information That Do Not Require Your Consent

We may use and disclose your Protected Health Information as follows without your permission:

For treatment purposes. We may disclose your health information to doctors, nurses and others who provide your health care. For example, your information may be shared with people performing lab work or x-rays.

To obtain payment. We may disclose your health information in order to collect payment for your health care. For instance, we may release information to your insurance company.

For health care operations. We may use or disclose your health information in order to perform business functions like employee evaluations and improving the service we provide. We may disclose your information to students training with us. We may use your information to contact you to remind you of your appointment or to call you by name in the waiting room when your doctor is ready to see you.

When required by law. We may be required to disclose your Protected Health Information to law enforcement officers, courts or government agencies. For example, we may have to report abuse, neglect or certain physical injuries.

For public health activities. We may be required to report your health information to government agencies to prevent or control disease or injury. We also may have to report work-related illnesses and injuries to your employer so that your workplace may be monitored for safety.

For health oversight activities. We may be required to disclose your health information to government agencies so that they can monitor or license health care providers such as doctors and nurses.

For activities related to death. We may be required to disclose your health information to coroners, medical examiners and funeral directors so that they can carry out duties related to your death, such as determining the cause of death or preparing your body for burial. We also may disclose your information to those involved with locating, storing or transplanting donor organs or tissue.

For studies. In order to serve our patient community, we may use or disclose your health information for research studies, but only after that use is approved by UWM's Institutional Review Board or a special privacy board. In most cases, your information will be used for studies only with your permission.

To avert a threat to health or safety. In order to avoid a serious threat to health or safety, we may disclose health information to law enforcement officers or other persons who might prevent or lessen that threat.

For specific government functions. In certain situations, we may disclose health information of military officers and veterans, to correctional facilities, to government benefit programs, and for national security reasons.

For workers' compensation purposes. We may disclose your health information to government authorities under workers' compensation laws.

Uses and Disclosures of Your Protected Health Information That Offer You an Opportunity to Object

In the following situations, we may disclose some of your Protected Health Information if we first inform you about the disclosure and you do not object:

To your family, friends or others involved in your care. We may share with these people information related to their involvement in your care or information to notify them as to your location or general condition. We may release your health information to organizations handling disaster relief efforts.

Uses and Disclosures of Your Protected Health Information That Require Your Consent

The following uses and disclosures of your Protected Health Information will be made only with your written permission, which you may withdraw at any time:

For research purposes. In order to serve our patient community, we may want to use your health information in research studies. For example, researchers may want to see whether your treatment cured your illness. In such an instance, we will ask you to complete a form allowing us to use or disclose your information for research purposes. Completion of this form is completely voluntary and will have no effect on your treatment.

For any other purposes not described in this Notice. Without your permission, we will not use or disclose your health information under any circumstances that are not described in this Notice.

Your Rights Regarding Your Protected Health Information

You have the following rights related to your Protected Health Information:

To inspect and request a copy of your Protected Health Information. You may look at and obtain a copy of your Protected Health Information in most cases. You may not view or copy psychotherapy notes, information collected for use in a legal or government action, and information which you cannot access by law. If we use or maintain the requested information electronically, you may request that information in electronic format.

To request that we correct your Protected Health Information. If you think that there is a mistake or a gap in our file of your health information, you may ask us in writing to correct the file. We may deny your request if we find that the file is correct and complete, not created by us, or not allowed to be disclosed. If we deny your request, we will explain our reasons for the denial and your rights to have the request and denial and your written response added to your file. If we approve your request, we will change the file, report that change to you, and tell others that need to know about the change in your file.

To request a restriction on the use or disclosure of your Protected Health Information. You may ask us to limit how we use or disclose your information, but we generally do not have to agree to your request. An exception is that we must agree to a request not to send Protected Health Information to a health plan for purposes of payment or health care operations if you have paid in full for the related product or service. If we agree to all or part of your request, we will

put our agreement in writing and obey it except in emergency situations. We cannot limit uses or disclosures that are required by law.

To request confidential communication methods. You may ask that we contact you at a certain address or in a certain way. We must agree to your request as long as it is reasonably easy for us to do so.

To find out what disclosures have been made. You may get a list describing when, to whom, why, and what of your Protected Health Information has been disclosed during the past six years. We must respond to your request within sixty days of receiving it. We will only charge you for the list if you request more than one list per year. The list will not include disclosures made to you or for purposes of treatment, payment, health care operations if we do not use electronic health records, our patient directory, national security, law enforcement, and certain health oversight activities.

To receive notice if your records have been breached. Hancock Public Health will notify you if there has been an acquisition, access, use or disclosure of your Protected Health Information in a manner not allowed under the law and which we are required by law to report to you. We will review any suspected breach to determine the appropriate response under the circumstances.

To obtain a paper copy of this Notice. Upon your request, we will give you a paper copy of this Notice.

If you have any questions about these rights, please contact us.

How to Complain about Our Privacy Practices

If you think we may have violated your privacy rights, or if you disagree with a decision we made about your Protected Health Information, you may file a complaint with our Privacy Officer by writing to Laura Reinhart APRN-CNP, Director of Nursing at lreinhart@hancockph.com.

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services by writing to 200 Independence Avenue SW, Washington, D.C. 20201 or by calling 1-877-696-6775.

We will take no action against you if you make a complaint to either or both of these persons.

How to Receive More Information About our Privacy Practices

If you have questions about this Notice or about our privacy practices, please contact our Privacy Officer, Laura Reinhart APRN-CNP, Director of Nursing, Hancock Public Health.

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. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

I, the undersigned, hereby certify and attest that I have agreed to the medical treatment, testing or to receive vaccines/TB testing at Hancock Public Health. I therefore authorize the medical staff and personnel to release my or my minor child's medical information to the insurance company I provided for the purpose of determining and receiving benefits for medical bills. I understand and acknowledge that the medical staff will submit my claim to the insurance company on my behalf. I further understand that I will be held responsible for any amount of my medical bills not covered by my insurance policy or claims, and that I will be responsible for paying all deductibles, fees, co-payments, and co-insurance payments required. I understand that any portion of my medical bills not covered by insurance will be billed to me at the address I have provided. This signature also serves as an acknowledgement that I have received the *Consent for Service and Financial Responsibility and Notice of Privacy Practices*.

Patient/Responsible Party Signature and Date: _____