



MULTICARE HEALTH CENTER
3840 SOUTH HARLEM AVENUE
LYONS, IL 60543
P: 708.442.3050 | F: 708.442.3058

NOTICE OF HEALTH INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW TO GET ACCESS TO YOUR INFORMATION.

PLEASE READ AND REVIEW CAREFULLY. EFFECTIVE IMMEDIATELY.

We understand that the medical information about you and your health is personal. We are committed to treating and using that Protected Health Information (PHI) about you responsibly. This notice of health information practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information.

Consent

1. The practice may use/disclose your PHI provided that it first obtains a valid consent signed by you. The consent will allow the practice to use/or disclose your PHI for the purpose of:
 - a. Treatment: In order to provide you with the health care you require, the practice will provide you PHI to those health care professionals, whether on the practice's staff or not, directly involved in your case so that they may understand your health condition and specific needs. For example, a physician treating for your lower-back pain may need to know the results of your latest physical examination by this office.
 - b. Payment: In order to receive payment for services provided to you, the practice will provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing requirements. For example, the practice may need to provide Medicare with information about health care services that you received from the practice so that the practice may be reimbursed. The practice may also need to tell your insurance plan about the treatment you will be receiving so that it can determine whether it will cover the treatment expenses.
 - c. Health Care Operations: In order to practice and operate in accordance with applicable law and insurance requirements in order for the practice to continue to provide quality and efficient care, it may be necessary for the practice to compile, use and/or disclose your PHI. For example, the practice may use your PHI in order to evaluate the performance of the practice's personnel providing care to you.

No consent required

1. The practice may use/or disclose you PHI, without a written consent from you, in the following instances:
 - a. De-identified Information: Information that does not identify you, your name or information without your name used to identify you.
 - b. Business Associate: To a business associate if the practice obtains satisfactory written assurance, in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the practice in undertaking some essential function, such as billing services that assists the practice in submitting claims for payment to insurance companies or other payers.
 - c. Personal Representative: A person under applicable law, who has the authority to represent you in decision making related to your health.
 - d. Emergency Situations:
 - i. For the purpose of obtaining or rendering emergency treatment to provide that the practice attempts to obtain your consent as soon as possible; or
 - ii. To a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.
 - e. Communication Barriers: If, due to substantial communication barriers or inability to communicate, the practice has been unable to obtain your consent and the practice determines, in its professional judgment, that your consent to receive treatment is clearly inferred from the circumstances.
 - f. Public Health Activities: Information collected by a public health authority, as authorized by law, to prevent/control disease.
 - g. Abuse, Neglect or Domestic Violence: To a government authority if the practice is required by law to make such disclosures. If the practice is authorized by law to make such a disclosure, it will do so if it believes that the disclosure is necessary to

prevent serious harm.

- h. Health Oversight Activities: Activities which required by law, involve governmental agencies and may include criminal investigation, disciplinary actions, or general oversight activities relating to the communities health care system.
- i. Judicial and Administrative Proceedings: Practice may be required to disclose PHI in response to a court order or a lawfully issued subpoena.
- j. Law Enforcement Purposes: Your PHI may be subject of a grand jury subpoena. Or the practice may release your PHI if it believes your death was result of criminal conduct.
- k. Coroner or Medical Examination: The practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining the cause of death.
- l. Organ, Eye, Tissue Donation: If you are an organ donor, the practice may disclose your PHI to the entity to whom you have donated the organs.
- m. Research: If the practice is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of you PHI.
- n. Avert a threat to Health or Safety: The practice may disclose your PHI if it believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to an individual who is reasonably able to prevent or lessen the threat.
- o. Specialized Government Function: This refers to disclosure of PHI that relate to military and veteran activity.
- p. Workers Compensation: If you are involved in a worker's compensation claim; the practice may be required to disclose your PHI to an individual or entity that is part of the workers compensation system.
- q. National Security and Intelligence Activities: The practice may disclose your PHI in order to provide authorizes governmental officials with necessary intelligence information for national security activities and purposes authorized by law.
- r. Military and Veterans: If you are a member of the armed forces, the practice may disclose your PHI as required by the military authorities.

Appointment Reminder

1. The practice from time to time may contact you to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you. The following appointment reminders are used by the practice:
 - a. A postcard mailed to you at the address provided by yourself.
 - b. Telephoning your home and leaving a message on your answering machine or with an individual that answers the phone.

Directory/Sign-In Log

1. The practice maintains a directory of sign-in logs for individuals seeking care and treatment in the office. The directory and sign-in log are located in a position where staff can readily see who is seeking care in the office, as well as the individual's location within the practice's office suite. This information may be seen by, and is accessible to others who are seeking care or services in the practice's office.

Family/Friends

1. The practice may disclose to your family member, other relative, a close personal friend, or any other person identified by you, your PHI directly relevant to such person's involvement with your care or the payment for the care. The practice may also use or disclose your PHI to notify or assist in the notification (including identifying or locating) a family member, a personal representative, or another person responsible for your care, your location, general condition or death. However, in both cases the following conditions will apply:
 - a. If you are present at or prior to the use or disclosure of your PHI, the practice may use or disclosure your PHI if you agree, or if the practice can reasonably infer from the circumstances, based on the exercise of its professional judgment, that you do not object to the use or disclosure.
 - b. If you are not present, the practice will, in the exercise of professional judgment, determine whether the use or disclosure is in your best interests. If so, disclose only the PHI that is directly relevant to the person's involvement with your care.

Authorization

1. Uses and/or disclosures, other than those described above, will be made only with your written Authorization.

Your Rights

1. You have the right to:
 - a. Revoke any authorization and/or consent, in writing, at any time. To request a revocation, you must submit a written request to the practice's privacy officer.
 - b. Request restrictions on certain use and/or disclosure of your PHI as provided by law. However, the practice is not obligated to agree to any requested restrictions. To request restrictions, you must submit a written request to the practice's privacy officer. In your written request, you must inform the practice of what information you want to limit, whether you want to limit the practice's use or disclosure, or both, and to whom you want the limits to apply. If the practice agrees to your request, the practice will comply with your request unless the information is needed in order to provide you with emergency treatment.
 - c. Receive confidential communications or PHI by alternative means or at alternative locations. You must make your request in writing to the practice's privacy officer. The practice will accommodate all reasonable requests.
 - d. Inspect and copy your PHI as provided by law. To inspect and copy your PHI, you must submit a written request to the practice's privacy officer. The practice can charge you a fee for the cost of copying, mailing or other supplies associated with your request. In certain situations that are defined by law, the practice may deny your request, but you will have the right to have the denial reviewed as set forth more fully in the written denial notice.
 - e. Amend your PHI as provided by law. To request an amendment, you must submit a written request to the practice's privacy officer. You must provide a reason that supports your request. The practice may deny your request if it is not in writing, if you do not provide a reason in support of your request, if the information to be amended was not created by the practice (unless the individual or entity that created the information is no longer available), if the information is not part of your PHI maintained by the practice, if the information is not part of the information you would be permitted to inspect and copy, and/or if the information is accurate and complete. If you disagree with the practice's denial, you will have the right to submit a written statement of disagreement.
 - f. Receive an accounting of your PHI as provided by law. To request an accounting, you must submit a written request to the practice's privacy officer. The request must state a time period which may not be longer than six (6) years and may not include dates before June 3, 2006. The request should indicate in what form you want the list (such as a paper or electronic copy). The first list you request within a twelve (12) month period will be free, but the practice may charge you for the cost of providing additional lists. The practice will notify you of the costs involved and you can decide to withdraw or modify your request before any costs are incurred.
 - g. Receive a paper copy of this privacy notice form the practice upon request to the practice's privacy officer.
 - h. Complain to the practice or to the secretary of HHS if you believe your privacy rights have been violated. To file a complaint with the practice, you must contact the practice's privacy officer. All complaints must be in writing.
 - i. To obtain more information on, or have your questions about your rights answered; you may contact the practice's privacy officer at Multicare Health Center.

Practice's Requirements

1. The practice:
 - a. Is required by federal law to maintain the privacy of your PHI and to provide you with the privacy notice detailing the practice's legal duties and privacy practices with respect to your PHI.
 - b. Is required by State law to maintain a higher level of confidentiality with respect to certain portions of our medical information that is provided for under federal law. In particular, the practice is required to comply with the following State statutes:
 - c. Is required to abide by the terms of this privacy notice.
 - d. Reserves the right to change the terms of this privacy notice and to make the new privacy notice provisions effective for your entire PHI that it maintains.
 - e. Will distribute any revised privacy notice to your prior to implementation.
 - f. Will not retaliate against you for filing a complaint.

Effective Date

This Notice is in effect as of June 3, 2006.



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PATIENT CONSENT TO THE USE & DISCLOSURE OF HEALTH INFO FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS & ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I, _____, understand that as part of my health care, paper and/or electronic records are originated and maintained 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.
- Means of communication among the many health professionals who contribute to my care.
- Source of information for applying my diagnosis and surgical information to my bill.
- Means by which a third-party payer can verify that services billed were actually provided.
- 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 information practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent.
- The right to object to the use of my health information for directory purposes.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that it 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 taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that the right is reserved to change this notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should the notice be changed, they will send a copy of any revised notice to the address I've provided (whether U.S. mail, or in agree, email).

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

_____ understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and **ACCEPT/DECLINE** the terms of this consent. (Must circle one)

I **CONSENT/REFUSE** to be treated. (Must circle one)

Patient's Signature _____ Date _____

I have been presented with a copy of the "Notice of Health Information Practices" detailing how my information may be used and disclosed as permitted under federal and State law. I understand the contents of the Notice, and I request the following restriction (s) concerning the use of my personal medical information:

I also understand that in order to file insurance benefits on my behalf, it will be necessary to release information regarding the medical treatment that I have received.

Signed: _____ **Date:** _____

Please Print Name Here: _____ **Witnessed By:** _____