

HIPAA – Notice Privacy

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review. Updated 11/20/2013

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or healthcare operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected health information is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related healthcare services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing healthcare services to you, to pay your healthcare bills, to support the operation of the physician's practice, and any other use required by law.

Treatment

We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time to time to another physician or healthcare provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your healthcare diagnosis or treatment to your physician.

Payment

Your protected health information will be used, as needed, to obtain payment for your healthcare services. For example, obtaining approval for a hospital procedure or stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital procedure or admission.

Healthcare Operations

We may use or disclose, as needed, your PHI in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, student training, licensing, fundraising, and conducting or arranging for other business activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

We may use or disclose your protected health information in the following situations without your authorization. These situations include:

- as Required By Law
- Public Health issues as required by law
- Communicable Diseases
- Health Oversight
- Abuse or Neglect
- Food and Drug Administration requirements
- Legal Proceedings
- Law Enforcement
- Coroners

- Funeral Directors
- Organ Donations
- Research
- Criminal Activity
- Military Activity
- National Security
- Workers' Compensation
- Inmates
- Required Uses and Disclosures

Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with any requirements.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your PHI.

Others Involved in Your Healthcare:

Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

Emergencies: We may use or disclose your PHI in an emergency treatment situation. If this happens, your physician shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your physician or another physician in the practice is required by law to treat you and the physician has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your PHI to treat you.

Communication Barriers: We may use and disclose your PHI if your physician or another physician in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the physician determines, using professional judgment, that you intend to consent to use or disclose under the circumstances.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your PHI for marketing purposes. We may not sell your PHI without your authorization. We may not use or disclose most psychotherapy notes contained in your PHI. We will not use or disclose any of your PHI that contains genetic information that will be used for underwriting purposes.

You may Revoke this Authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and receive a copy of your protected health information (fees may apply) Pursuant to your written request, you have the right to inspect and obtain a copy of your PHI whether in paper or electronic format.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of

your PHI not be disclosed to family members or friends who may be involved in your care. Your request must state the specific restriction requested and to whom you want the restrictions to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose PHI to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact.

You have the right to obtain a paper copy of this notice from us, upon request. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

You have the right to request amendment to your protected health information. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. You can request an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred six years prior to the date the request.

Complaints

You may complain to us or to if you believe your privacy rights have been violated by us. You may file a complaint with us in writing by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

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 PHI.

Compliance Officer's contact information is listed below:

Mao Vue mvue@asiaohio.org

330-535-3263

The date on which this Notice of Privacy Practices first takes effect is November 20, 2013.

Name:



Authorization Form

MR#:

International Community

Authorization

The information received on this application is confidential and will be used to review your current situation.

Authorization for Representation

Purpose

I, the undersigned hereby authorize International Community Health Center employees to discuss and provide copies of my medical and financial file in their efforts to research financial and medical resources on my behalf.

Authorization for Release of Information

Medical Information

This authorization includes the release to International Community Health Center of all clinic and medical information, electrocardiograms, immunization and allergy records, labs, x-rays and eye reports.

I also give special permission for the release to International Community Health Center of mental health, alcohol, HIV (AIDS), drug abuse and developmental disability information pertaining to my file.

Financial Information

This authorization includes the release to International Community Health Center of any financial statements, business reports, pay roll or benefit information from my past or present employers, banks or other financial institutions, credit bureaus or government agencies. This is for the purpose of verifying any health insurance coverage and proper billing.

Other Related Information

Finally, I authorize the release to International Community Health Center of any other related information, including psychological, social, vocational, rehabilitative, or educational reports, assessments or evaluations.

I authorize the release of the above information for the dates up to and including the date of my signature, and for up to one year from the date of my signature.

I understand written notification is required by me to revoke this authorization. I also understand that a photocopy of this authorization has the same effect as the original.

I hereby certify the above information is correct and complete to the best of my knowledge.

Signature of Responsible Party: _____ Date: _____

Signature of Patient: _____ Date: _____

Optional:

I also authorize _____, who is my _____, to discuss my
(name of individual) (specify relationship)
application status with any member of the International Community Health Center Staff.

If signed by person other than patient, state relationship and authority to do so.

Patient is: minor / incompetent / disabled Your authority: parent / legal / legal guardian

For ICHC Representatives

Name (Print): _____ Signature: _____ Date: _____



Consent Form

Patient Name: _____

Medical Record# _____

1. Consent to treat: ____ (initials)

I hereby authorize International Community Health Center and all its included departments to render any health services and treatment that is deemed necessary, to me in accordance with the policies and procedures of the Health Center. I understand that I retain the right to refuse any or all of the recommended treatment.

2. Consent to Share Medical Records: ____ (initials)

I understand that my medical record information could be shared within the different departments of the International Community Health Center. The information will be shared only to help in my health care assessment and management.

I also understand that at any time during the course of my medical treatment, a referral to a specialist is required, certain laboratory results and/or details from the medical record could be forwarded to the specialist. This will be done solely to assist in my complete evaluation.

I hereby authorize International Community Health Center to release my medical records to be reviewed for the purposes of an Audit and/or Evaluation. (The purpose of this review is to enhance patient care and to comply with managed care requirements). I understand that no identification of my name or address will be recorded during this review process.

3. Confidentiality: ____ (initials)

I understand that International Health Center adopts a very strict policy regarding privacy and confidentiality of my medical information. I have been given the privacy and confidentiality statement of the Health Center and have reviewed the information.

I understand that this consent in its entirety will remain in effect as long as I continue to receive health care services at International Community Health Center.

Signature of Patient

Date

Signature of Parent/Guardian

Signature of Witness