Community Health Partners Notice of Privacy Practices

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.

What is this Notice and Why it is Important

This notice is required by law to inform you of how your health information will be protected, how Community Health Partners may use or disclose your health information, and about your rights regarding your health information. The Notice covers all persons who are employees by or otherwise provide you with care through our organization. If you have any questions about this notice, please contact Community Health Partners' Privacy Office at (559) 724-4400.

Understanding Your Health Information

Each time you visit a physician, health care provider or hospital, a record of your visit is made. Typically, this record contains a description of your symptoms, medical history, examination and test results, diagnoses, treatment, and a plan for future care. This information, often referred to as your medical records, serves as a:

- Basis for planning your care and treatment
- Means of communication among the health professionals who contribute to your care
- Legal document of the care you receive
- Means by which you or a third-party payer (e.g., health insurance company) can verify that services you received are appropriately billed
- Tool for education health professionals
- Data source for medical research
- Source of information for public health authorities
- Source of data for planning facilities, marketing health care services, and fundraising
- Tool to facilitate routine health care
- Tool with which we can assess and work to improve the care we provide

Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand, who, what, when, where and why others may access your health information, and make more informed decisions when authorizing disclosures to others.

Your Health Information Rights

You have the following rights related to your medical and billing records kept at Community Health Partners:

Obtain a copy of this notice. You will receive a copy of this notice at your first visit after its publication. Thereafter you may request a copy of this notice or any revisions from our website https://www.communitymedical.org/Privacy or by calling the Health Information Department at (559) 459-3925.

Authorization to use your health information. Before we use or disclose your health information other than as described below, we will obtain your written authorization, which you may revoke at any time to stop future use or disclosures that constitute sale of your health information.

Access to your health information. You may request a copy of your health information that Community Health Partners keeps in your medical or billing record. Your request must be submitted in writing. We charge a nominal amount for the access costs.

Amend your health information. If you believe the information we have about you is incorrect or incomplete, you may request that we correct the existing information or add the missing information. Your request must be in writing and you may pick up a form for this purpose in the Health Information Management (Medical Records) Department. We reserve the right to accept or reject your request and will notify you of our decision.

Request confidential communications. You may request in writing that when we communicate with you about your health information, we do so in a specific way (e.g., at a certain mail address or phone number). We will make every reasonable effort to agree to your request.

Limit our use or disclosure of your health information. You may request in writing that we restrict the use or disclosure of your health information for treatment, payment, healthcare operations, or any other purpose except when specifically authorized by you, when we are required by law, or in an emergency situation in order to treat you. We will consider your request and respond, but we are not legally required to agree if we believe your request would interfere with our ability to treat you or collect payment for our services. However, if you pay out of pocket in full for the healthcare item or service then you have the right to restrict certain disclosures of your health information to a health plan.

Opting-Out of the Care Everywhere and Health Information Exchange. Community Health Partners and affiliated physicians participate in Care Everywhere (CE) and a Health Information Exchange (HIE); secure electronic systems for health care providers to share your medical information. Through CE and the HIE, your participating providers will be able to access information about you that is necessary for your treatment. You have the right to choose to have your information withheld from CE and the HIE by personally opting-out from participation. You do not have to participate in CE and the HIE to receive care. If you choose to opt-out of CE and the HIE (that is, if you feel that your medical information should not be shared through CE and the HIE), Community Health Partners and affiliated physicians will continue to use your medical information in accordance with this Notice and applicable law, but will not make it available to other health care providers through CE and the HIE. To opt-out of CE and the HIE, please request a form from Community Health Partners' Health Information Management Department at (559) 459-3925 and the form will be mailed to you.

Accounting of disclosures. You may request a list of disclosures of your health information that we have made for reasons other than treatment, payment, or healthcare operations. Disclosures that we make with your authorization will not be listed. The first list you request within a 12 month period will be free. We may charge you for additional lists.

Our Responsibilities

We are required by law to protect the privacy of your health information, establish policies and procedures that govern the behavior of our workforce and business associates, and provide this notice about our privacy practices. In the event of any breach of unsecured protected health information, we shall fully comply with the HIPAA/HITECH breach notification requirements, which will include notification to you of any impact that breach may have had on you and/or your family member(s) and actions we undertook to minimize any impact the breach may or could have on you.

We reserve the right to change our policies and procedures for protecting health information. When we make significant change in how we use or disclose your health information, we will also change this notice. The new notice will be posted on our website, and will be available at the information desk and in our medical records departments.

Except for the purposes related to your treatment, to collect payment for our services, to perform necessary business functions, or when otherwise permitted or required by law, we will not use or disclose your health information without your authorization.

You have the right to revoke your authorization at any time. We are unable to take back any disclosure we have already made with your permission.

For More Information or to Report a Problem
If you have questions, would like additional information, or want to request an updated copy of this notice, you may contact the Health Information Department at (559) 459-3925 or the Privacy Office at (559) 724-4400.

If you believe we have not properly protected your privacy, have violated your privacy rights, or you disagree with a decision we have made about your rights, you may contact Community Health Partners Privacy Officer listed at the top of the Notice of Privacy Practices. You may also send a written complaint to the:

U.S. Department of Health and Human Services
Office of Civil Rights Attn: Regional Manager
90 7th Street, Suite 4 -100 San Francisco, CA 94103
1-415-437-8310

Community Health Partners will ensure that you will not be penalized nor will the care you receive at our facilities be impacted if you file a complaint.

Examples of Uses & Disclosures for Treatment, Payment & Healthcare Operations
We will use your health information to facilitate your medical treatment.
For example: Information obtained by a nurse, physician, or other members of your healthcare team will be recorded in your record and used to determine the course of your medical treatment. We will provide your physician, or other healthcare providers involved with your treatment (e.g., specialists, consulting physicians, anesthesiologists, therapists, etc.) with copies of various reports that may assist them in treating you.

We will use your health information to collect payment for health care services that we provide.
For example: A bill may be sent to you or your health insurance company. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used. In some cases, information from your medical record is sent to your insurance company to explain the need for or provide additional information about your treatment. We may also disclose medical information to other healthcare providers to assist them in obtaining payment for services they have provided to you

We will use your health information to facilitate routine healthcare operations.
For example: Members of our medical staff or quality improvement teams may use information in your record to assess the care you have received and how your progress compares to others.

We will use your health information to help us educate medical staff, residents and students.
For example: Community Health Partners has associations with a variety of schools involved in the education of health professionals. All staff, residents, and students must sign a confidentiality agreement before accessing any health information maintained by Community Health Partners.

We will use your health information to notify your family and friends about your condition or in the event of your death.
For example: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care on your general condition. Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, relevant health information to facilitate the person's ability to assist you in your care or make arrangements for payment of your care.

We may use your health information to inform persons about your death.
For example: We may disclose health information to funeral directors, coroners and medical examiners consistent with applicable law to carry out their duties.

Examples of Uses and Disclosures for Other Purposes
Appointment Reminders: We may contact you to provide appointment reminders.

Alternative Treatments: We may use your health information to provide you with information about the availability of alternative treatments that are within the range of options for your condition.

Fundraising: We are a community-based, not-for-profit organization that depends extensively on charitable support. We may disclose limited information about you, such as your name, address, demographic information, and the dates you received treatment to our fundraising foundation so that they may inform you of opportunities to support Community Medical Centers, its services and programs. You do have the right to opt out of fundraising communications.

Research: We may contact you to request your participation in an authorized research study. In some cases, we may disclose your health information to researchers when an institutional review or privacy board has approved their research. Prior to giving any information, special procedures will be established to protect the privacy of your information.
Sign in Sheet: We may use and disclose medical information about you by having you sign in when you arrive at our facility. We may also call out your name when we are ready to see you.

Workers Compensation: We may disclose your health information to your employer and workers compensation carriers as authorized by laws relating to workers compensation or other similar programs established by law.

As Required by Law: We will use and disclose your health information to comply with state and federal laws, which include reporting abuse, neglect, or domestic violence, responding to judicial or administrative proceedings, complying with audits, responding to law enforcement officials, reporting health and safety threats, reporting to public health authorities or other federal agencies.

Food and Drug Administration (FDA): We may disclose to the FDA your health information relating to adverse events with respect to food, nutritional supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacement.

Device Manufacturers: If you receive a medical device that is implanted or which is used for life support function we may disclose your name, address, and other information as required by law to the device manufacturer for tracking purposes. You may refuse to authorize the disclosure of your name and contact information.

Business Associates: There are some services provided in our organization through contracts with business associates. Examples include certain laboratory tests, patient satisfaction surveys, and the copy service we use when making copies of your health record. When these services are provided by contracted business associates, we may disclose the appropriate portions of your health information to our business associates so they can perform the job we have assigned to them. To protect your health information,

however, we require all business associates sign a confidentiality agreement verifying they will appropriately safeguard your information.

Specialized Government Functions: We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

I acknowledge that I have received a copy of Community Health Partners Notice of Privacy Practices. I understand that the Notice of Privacy Practices describes how Community Health Partners may disclose and use my protected health information. I am encouraged to read the Notice of Privacy Practices in full.

Patient Name: MRN:

Date:_____ Time:_____ Signature:_____

Patient/Legal Representative/Guardian

If signed by the patient's representative/guardian, indicate:

1. a. Name of Signer: _____
2. b. Relationship to patient: _____

[ ] Decline to Sign Acknowledgement or Inability to Obtain Acknowledgement:

If acknowledgement is not signed, indicate reason not signed and efforts made to have acknowledgement signed:

[ ] Patient/representative/guardian declines to sign

[ ] Emergency condition prevented signature

[ ] Other, describe below

Print Name/Title: _____

Date:_____ Time:_____ Signature: _____

(CHP Employee)

Interpreter Signature if Applicable

I have accurately and completely read the foregoing document to

_____ in _____, the patient's or legal
(Patient or Legal Representative Name) (language)

representative's primary language.

(He/she) understood all of the terms and conditions and acknowledged (his/her) agreement thereto by signing the document in my presence.

_____ _____

Date / Time Interpreter Signature / Print Name / Title

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Label