Sulzbacher Health Center

Notice of Privacy Practices
(You Keep This)

This Notice of Privacy Practices describes how we use and disclose your health information, how you can get access to this information, your rights concerning your health information and our responsibilities to protect your health information. We are required by State and Federal laws to provide you with this Notice and we will comply with its terms during the period when it is in effect. The Notice will take effect on February 23, 2016 and will remain in effect until it is amended or replaced by the Health Services Administrator and Board of Directors. You have a right to a copy of any new revisions if they should become necessary.

Treatment: We may use clinical information about you to provide you with clinical treatment or services. We may also disclose clinical information about you to other doctors and/or specialty care providers, counselors, medical caseworkers or other authorized personnel involved in your care.
For example: A doctor may need to tell the specialty doctor who you were referred to about medication that was prescribed and if any medications need to be prescribed after your visit with the specialty doctor. We may share information with outside people if they are also responsible for services related to those you receive here.

For Payment: We may use and disclose clinical information about you so that treatment and services you receive at the center may be billed to and payment may be collected. This disclosure involves our billing staff, insurance organizations, collections and/or a third party payor.
For example: We may need to inform your health plan about treatment you are going to receive to obtain prior approval so your plan will cover treatment. We may need to share information with your insurance company about your treatment plan so your health plan will pay us or to reimburse you.

Disclosure: We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree If an individual is deceased you may disclose PHI to a family member or individual involved in care or payment prior to death. Psychotherapy notes will not be used or disclosed without your written authorization. Genetic Information Nondiscrimination Act (GINA) prohibits health plans from using or disclosing genetic information for underwriting purposes. Uses and disclosures not described in this notice will be made only with your signed authorization.

Other Uses of Your Clinical Information: Other uses and disclosures of clinical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us with written permission to use or disclose clinical information about you, you may revoke that permission, in writing, at any time.

If you revoke your permission, we will no longer use or disclose clinical information about you for the reasons covered in your written authorization.

We are unable to take back any disclosures we have already made with your permission.

We are required to retain our records of the care we provided to you.

Your Rights Concerning Privacy of Your Clinical Information: You have the right to inspect and receive a copy of your clinical information including clinical and billing records. To inspect and request a copy of your clinical information that may be used to make decisions about you, you must submit a request in writing.

If you request a copy, we may charge a fee to cover the cost of copying, mailing, or other costs of other supplies associated with your request.

You have the right to request to amend clinical information you feel is incorrect or incomplete. You may request an amendment for as long as we keep the information.

To request an amendment, your request including a reason to support the request, must be in writing.

We may deny the request for the amendment of clinical information. We may deny your request for amendment if it is not in writing.

We may deny your request for amendment if it does not include a reason to support the request.

We may deny your request for amendment if the information you are requesting to amend was not created by us; unless, the person that created the information is no longer available to make the amendment.

We may deny your request for amendment if it is not part of the information kept by the center.

We may deny your request for amendment if it is not part of the information you would be permitted to inspect.

We may deny your request for amendment if the information is accurate and complete.

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For Health Care Operations:

We may use and disclose your Protected Health Information (PHI) for internal purposes regarding your care. For Example: We may use information within our organization to acquire additional recommended treatment possibilities from other clinicians with other experience. Our organization may use information for learning purposes. Our organization may use information to evaluate the performance of our staff in providing services to you. We will use this information for appointment reminders. Our organization may use this information to tell you about treatment alternatives.

We may disclose your PHI externally with appropriate releases as required. For Example: Our organization may release information to your insurance company, caregiver, or someone who helps pay for your care. Our organization may release information to disaster relief personnel to locate family or you if necessary. Our organization may combine information from our center with that of other centers for quality review and for evaluating services offered or for research. Our organization may remove information that identifies you from this information.

We will seek specific permission if researchers have access to information that would identify you. We will disclose information about you when required by federal, state, or local law.

Other uses and disclosures we are allowed to make without your explicit authorization. We may release information about you:

For public health activities: These would generally include: report of child or adult abuse or neglect, to notify people of recalls of products, to notify authorities of a victim of abuse, neglect, or domestic violence when authorized by the patient or required by law, and prevention or control of disease.

To a health oversight agency as authorized by law

If you are involved in a lawsuit- in response to a court or administrative order, or in response to a subpoena, delivery request, or other lawful process by another party in the dispute. Efforts will be made to tell you about the request.

To a coroner or medical examiner: To authorize federal officials in service to protect the President, other heads of state, or conduct special investigations.

To the institution or official if you are an inmate of a correctional institution or under custody of law enforcement officials.

To a law enforcement official in response to a court subpoena, warrant summons, or other lawful process, to identify a suspect, fugitive, witness, or missing person, about a victim, criminal conduct or criminal death. For emergency circumstances concerning crime information.

If you are a member of the armed forces as required by military command authorities.

Your Rights Concerning Privacy of your Protected Health Information: Individuals seeking treatment have the right to request that we restrict our uses and disclosures of their PHI. We are not obliged to agree to those restrictions, but if we do, we must abide by them. Therefore, restrictions to consent will not be granted without the express permission of the Medical Director and/or Health Services Administrator who will evaluate an individual's request and determine:

1) **if the restrictions are reasonable and**
2) **if it is possible to implement the restriction in our practice**

Should the request be granted, the consent form will reflect the restrictions allowed.

Your request must tell us what information you want to limit, whether you want to limit use or disclosure or both and who you want the limits to apply to. Your request must be made in writing.

Breach Notification Requirements. It is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

Questions and Complaints:
You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to the Office Manager. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. We supportyour right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services. HOW TO CONTACT US:

SULZBACHER HEALTH CENTER

Downtown Clinic
611 East Adams Street
Jacksonville, Florida 32202
(904) 394-4958
stacimagruder@sulzbacherjax.org

Beaches Clinic
850 6th Avenue South
Jacksonville, Florida 32250
(904) 394-4958
stacimagruder@sulzbacherjax.org

Village Pediatric Clinic
5455 Springfield Boulevard
Jacksonville, Florida 32208
(904) 394-4958
stacimagruder@sulzbacherjax.org

Sulzbacher Center

Disclosure of Protected Health Information and Privacy Authorization Form

Patient Name: _____
Last First Middle

Address: _____
Street City State Zip Code

SSN#: _____ Date of Birth: _____ Tel. No: _____

1. Disclosure of Health Information for Treatment, Payment & Healthcare Operations

I consent to the use and disclosure of my protected health information for treatment, billing and healthcare operations. I have been given a copy of the Notice of Privacy Practices and understand that I have the following rights and privileges:

- The right to review the Notice prior to signing the consent
- The right to inspect and receive a copy of my clinical information
- The right to request to amend clinical information I feel is incorrect or incomplete
- The right to request that Sulzbacher restricts its use and disclosure of my personal health information
- The right to revoke my permission at any time by giving written notice to Sulzbacher

This authorization will remain in effect until my death or the day I withdraw my permission (in writing)

I, _____, have read this consent form and the Notice of Privacy Practices. I understand that I am giving you consent to use and disclose my health information for treatment, billing and healthcare operations.

_____ _____
Signature of Patient Date

2. HIPAA Privacy Authorization Form

Who can see my health information? Please list any family members or others who may be involved in coordinating your care.

Name	Relationship to Patient

How long can they see my information?

☐ From _____ to _____

☐ All past, present and future periods

What can they see?

- ☐ Everything
- ☐ Everything EXCEPT the following (check all that apply)
  - ☐ Mental health records
  - ☐ HIV/AIDS/Other communicable diseases
  - ☐ Alcohol /drug abuse treatment
  - ☐ Other, specify: _____

This medical information may be used by the person I authorize for medical treatment, billing or claims, discussions about my health, or other purposes that I allow.

I understand that I have the right to revoke this authorization (in writing) at any time. I understand that any revocation is not effective on any information that has already been shared. I understand that I can refuse to sign this release and that my treatment, payment, enrollment, or eligibility for services will not be withheld.

_____ _____

Signature of Patient **Date**