MORROW COUNTY HEALTH DISTRICT
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND SHARED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. (Effective: 7/8/14)

Our Legal Duty

We understand that health information about you is personal. We are committed to protecting your health information. We are required by federal and state laws to keep your health information protected and to tell you about how we may share it. We must also tell you about our legal duties and your rights concerning your health information. If we change the way we protect your information, this form will be updated and you may ask for a copy.

Ways We Use and Share Health Information

Your information may be shared in three main ways:

Treatment: We may share your health information internally with doctors, nurses, nursing students or other professionals involved in your care; with a healthcare provider who is treating you; with other programs providing services to you; to refer you to a specialist; or to refer you to another program at the Health Department. If you are in the military we may share your information with them if it helps provide care to you. Unless you tell us not to, we may send mail, call, text or or e-mail you to remind you about an appointment.

Payment: We may share your information to determine eligibility for coverage of services, or to get payment for services you receive. For example, we will tell your health insurance company about the services you have received so they can pay the bill.

Health Care Quality: We may use or share your information for certain administrative, financial, legal, and quality improvement activities of the MCHD that are necessary to run its business and to support the core functions of treatment and payment. We will use your information to be sure what we have is correct and complete, to be sure you're getting all the services you need, or to train new healthcare workers.

Other ways we may share your information:

To You or with Your Permission: We can always give you your information or we can share it with someone else with your written permission. If you tell us, in writing, to stop sharing it with those persons, this will only stop future sharing of information and will not undo the information previously shared.

To Your Family and Friends: We may share your health information with someone to give you the care you need, to let them know where you are or that you have been hurt or killed, or to help in paying the bill. We will do this with your permission unless you can't give permission or it is an emergency.

To a School: With your verbal or written permission we will share your, or your child's, immunization record with a school, college, or other educational program requiring immunizations for entry. We will keep a record of when and to which school the information was released.

To Prevent a Public Health Threat: We may share your information to prevent or investigate a disease outbreak; to prevent injury to others; to report births and deaths; and to help notify you when product recalls happen. This also includes anything needed to prevent or lessen any serious threat to the health or safety of any person including threats

to national security or the President.

For Research: Under certain circumstances, MCHD may use and disclose de-identified health information for research purposes. For example, a research project may study vaccination rates of specific age groups. All research projects are subject to a special approval process. Before we use or disclose health information for research purposes, we will almost always ask for a client's specific permission if the researcher will have access to a clients's name, address, or other information that reveals who a client is.

To Business Associates: Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, legal services, etc. At times it may be necessary for us to provide certain personal health information to one or more of these outside persons or organizations who assist us with our healthcare operations. In all cases, we require these business associates to appropriately safeguard the privacy of your information.

Health Oversight Activities: We may legally share your health information with another government agency to improve the quality of the way your service is provided or billed. They may review records, licenses, inspections, or other documents or actions. For example, we are required to report to the Food and Drug Administration any adverse events, product defects, or participation in recalls. Oversight is needed to check on the quality of various parts of the health care system; government payment and licensing programs; and civil rights laws.

Abuse or Neglect: We may share your health information with local authorities if we believe that you or a child might be a possible victim of abuse, neglect, domestic violence or other crimes.

Coroners, Medical Examiners, Funeral Directors: We may share your information with a coroner or medical examiner in order to assist in determining the cause of death or to help a funeral director in doing their job.

Lawsuits: If you are part of a lawsuit, we may share your information if we get a court order to do so. This includes subpoenas, requests for information or other legal actions.

Inmates: If you, or your child, are an inmate of a jail or prison or in the custody of a law enforcement official, we may share health information about you or your child with them so that they can give you health care; for the care and safety of you or others; or for the safety and security of the correctional institution.

Other Disclosures: Uses and disclosures other than those described in this notice will be made only with your specific written permission. You have the right to revoke this permission in writing.

Your Rights Regarding Your Health Information

Right to See and Copy: You almost always have the right to look at or get copies of your or your minor child's health information. We will provide the information in paper or electronic format, depending upon the format in which it is maintained in our records. We will grant your request to the extent possible. We will give you the information you want if you have given us your consent to release and/or if we have your signed information release form on file. We may charge you for making copies, mailing them, or for other supplies or labor used in getting the information to you. In rare instances, we may deny your request to see or copy your information. If this happens, you can ask that the denial be reviewed. Another professional will be chosen to review your request, and we will follow their decision about giving you the information.

Right to Know if Information has been Shared: You have the right to get a list of times we have released your health information to someone else for reasons other than treatment, payment, or health care operations since April 4, 2003. If you ask for this and there are costs for giving it to you, we will let you know beforehand. You must ask for this record in writing.

Right to Restrict Certain Information Released to Health Plans: You have the right to ask us to restrict release of certain health information to a health (insurance) plan for payments or audits when you have paid out-of-pocket in full for the service.

Right to Ask for Restriction of Your Information: You have the right to ask us to put more restrictions on how your information is shared for your treatment, payment or quality reviews. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). You need to ask for this in writing. You must include in the letter: (1) what information you want us to restrict; (2) whether you want to limit our use of your information, sharing your information, or both, and (3) to whom the limits apply.

Right to Ask for Other Ways of Getting in Touch with You: You have the right to ask us to get in touch with you about your health in a specific way or at a specific place. For example, you can ask that we only contact you at work, not home, or by mail, not phone. You must ask us to do this in writing and you must tell us how and where you want us to contact you. We will not ask you why.

Right to Ask for Changes: You have the right to ask that we change your health information. You must ask for this change in writing and it must tell why the change is needed. There are some changes that we are not allowed to make; in those cases we must deny your request.

Electronic Notice: If you receive this notice on our web site, or by e-mail you can also ask for a paper copy.

Breach: You have the right to be notified of any breach of your unsecured protected health information.

Questions and Complaints

Information on our Privacy Practices: The MCHD has to follow what is in this notice. But, the MCHD has the right to change this notice at any time. We will provide you with a copy of any changes by posting them on our website and in our lobby. If you want more information about our privacy practices, have questions or have concerns, please contact us.

Filing a Complaint: If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about using or sharing your health information, you may send a written complaint to the contact person listed below. You may also send a written complaint either to the Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Hubert H. Humphrey Building, Washington, D.C. 20201, or to the Region V Office for Civil Rights – Celeste Davis, Regional Manager, Office for Civil Rights, U.S. Department of Health and Human Services, 233 N. Michigan Avenue, Suite 240, Chicago, IL 60601.

We support your right to protect the privacy of your health information. We 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.

For More Information or with Concerns, Contact:

Stephanie Bragg, RN, BSN, MHA
Director of Nursing
Morrow County Health District
619 West Marion Road, Suite B-143
Mount Gilead, Ohio 43338-1489
Phone: (419) 947-1545
Fax: (419) 946-6807

MORROW COUNTY HEALTH DEPARTMENT AUTHORIZATION
FOR THE RELEASE OF PERSONAL HEALTH INFORMATION

I have received a copy of the Notice of Privacy Practices and my questions have been answered.

PRINT YOUR NAME: *(person completing form)*

_____
LAST FIRST Middle Initial

RELATIONSHIP TO PATIENT:

- ☐ Self
- ☐ Custodial parent/legal guardian of child
- ☐ Legal guardian of adult
- ☐ Medical power of attorney
- ☐ Other_____

PATIENT NAME: *(if different than above)*

_____
LAST FIRST Middle Initial

PATIENT ADDRESS:

_____
Street Address *(w/ apt. no. if applicable)*

_____ _____
City Zip

PATIENT PHONE: ___(_____)_____

I authorize the release of information to the patient and the following **FAMILY MEMBERS**:

_____

_____

I prefer you **CONTACT ME** via:

- ☐ Cell phone: ___(_____)_____
- ☐ Home phone: ___(_____)_____
- ☐ Work phone: ___(_____)_____
- ☐ Text message: ___(_____)_____
- ☐ Email: _____
- ☐ Mailing address:

_____
City_____ State____Zip_____

If the Health Department can't reach me directly by mail or phone, I authorize the staff to contact the following person(s) to obtain my current contact information.

ALTERNATE CONTACT PERSON'S NAME:

_____
LAST FIRST Middle Initial

ALTERNATE CONTACT'S ADDRESS:

_____
Street Address *(w/ apt. no. if applicable)*

_____ _____
City Zip

ALTERNATE CONTACT'S PHONE: ___(_____)_____

RELEASE TO SHARE INFORMATION:
I hereby give permission for the Morrow County Health District to obtain and/or release information as described in the MCHD Notice of Privacy Practices to provide services. As required to provide services, MCHD may request or release:

- ☑ Health records
- ☑ Insurance status or covered benefits
- ☑ Income verification
- ☑ Medical birth information *(add'l form required)*

From or To:

- ☑ Physician of record
- ☑ Specialty physician
- ☑ Other treating healthcare facility or provider
- ☑ Referring agency
- ☑ Ohio Department of Health
- ☑ Other agencies providing care/service
- ☑ Third party payer *(e.g. health insurance)*

I understand that I may restrict how MCHD shares information by striking any of the items listed above or attaching separate instructions. However, MCHD cannot bill for services on my behalf without sharing information with the payer; in that case I will have to pay MCHD at the time of service. Further, I understand that MCHD may not have the information it needs to determine eligibility or provide me with services if I restrict certain information. I understand that I will be notified if my restrictions affect MCHD service delivery. I understand that MCHD must release information as required by law.

SIGNATURE:_____

DATE: _____/_____/_____ *(expires 2 years after this date)*

WITNESS SIGNATURE:_____

DATE: _____/_____/_____ *(expires 2 years after this date)*