Public Health
Prevent. Promote. Protect.
Tuscarawas County
Health Department

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

When you visit a hospital, a physician, or healthcare provider, you are establishing a healthcare record with that provider. Your healthcare record contains notes about your visit, including such things as your symptoms, examination, and test results, diagnoses, treatment, and a plan for future care or treatment. Your healthcare or medical record serves many purposes.

- It may be used to plan your care and treatment.
- It may be used to obtain payment from a third-party, such as an insurance company or Medicare and Medicaid.
- It is a means of communication among the man health professionals who contribute to your care.
- It is a legal document describing the care you received.
- It is a means by which you or a third-party payer can verify that services billed were actually provided.
- It may be a source of information for public health officials.
- It may be a source of data for facility planning and marketing.
- It may be a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used help you to ensure its accuracy. It also helps you to understand who may access your health information and under what conditions, and it helps you to make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS

The physical record of your health is the property of the healthcare practitioner or facility that compiled it. However, the underlying information belongs to you. You have the right to:

- Request restrictions on certain uses and disclosures of your information; however we do not have to comply with your request.
- Obtain a paper copy of the notice of information practices upon request.

897 E. Iron Ave.
Dover, OH 44622
(330) 343-5555
(330) 343-1601
www.tchdnow.org
director@tchdnow.org

- Inspect and obtain a copy of your health record, except in limited circumstances (you will be charged a reasonable fee for copying).
- Request communications of your healthcare record.
- Obtain an annual accounting of disclosures of your health information (you will be charged for additional accountings).
- Request communications of your health information by alternative means or at alternative locations.
- Revoke your authorization to use or to disclose health information except to the extent that action has already been taken.

We do not have to honor your request for restrictions on activities that are otherwise allowable under law. Any request for restrictions on use or disclosures must be made in writing. We will notify you within 30 days of our decision. We may request an additional 30 days to consider your request.

OUR RESPONSIBILITIES

We are required to:

- Maintain the privacy of your health information.
- Provide you with a Notice of Privacy Practices that describes our legal duties and privacy with respect to information we collect and maintain about you.
- Abide by the terms of our Notice of Privacy Practices.
- Notify you if we will not agree to a requested restriction.
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices at any time and to make any new provisions effective for all the protected health information we maintain. Prior to making any significant changes in our privacy practices, we will change our Notice of Privacy Practices and post the Notice in the waiting and the examination rooms. You will be provided a copy of our new Notice of Privacy Practices if any of our information or our practices change. We will not use or disclose your health information without your authorization, except as described in this notice.

We will use your health information for treatment: For example: Information obtained by your doctor, our nurses, and any other employees of this facility is recorded in your record and is used to determine the course of treatment that should work best for you. Your doctor also documents in your record his or her expectations of recommended treatment. Individuals involved in your treatment record the actions they take and their observations. In that way, the physician will have a more complete picture of your health. We will also provide any subsequent physician or healthcare provider with copies of your healthcare information that should assist him or her in continuing your course of treatment.

We will use your health information for payment: For example: We will bill you or a third-party payer for payment of healthcare services rendered. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used. This information is necessary in order for us to obtain payment.

We will use your health information for regular health operations: For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes

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in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business Associates: There are some services provided in our organization through contacts with business associates. Examples: Certain laboratory tests and computer system consultants and contracted medical personnel. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information. The Business Associate is obligated to protect your information in the same manner as we do.

Notification: We may use or disclose your information to notify or assist in notifying a family member, personal representative, or another person ***responsible for your care***, your location and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information **relevant** to the person's ***involvement in your care or payment of your care***.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral Directors: We may disclose health information to funeral directors consistent with the applicable law to carry out their duties.

Organ Procurement Organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donations and transplants.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Fund Raising: We may contact you as part of a fund-raising effort.

Food and Drug Administration: We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Worker's Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with the laws relating to workers compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to the public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Correctional Institution: If you are an inmate of a correctional institution, we may disclose to

the instruction or agents thereof information necessary for your health and the health and safety of other individuals.

Law Enforcement: We may disclose health information for law enforcement purposes as required by law or in response to valid court order or subpoena. Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangered one or more patients, workers, or the public.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions and would like additional information, you may contact the Director of Nursing or designee at the Tuscarawas County Health Department at (330) 343-5555.

If you believe your privacy rights have been violated, you can file a complaint with the Executive Director or designee at the Tuscarawas County Health Department or with the Secretary of Health and Human Services.

There will be no retaliation for filing a complaint.

OUR LEGAL DUTY

We are required by law to protect the privacy of your information, provide this Notice about our information practices, and follow the information practices that are described in this notice.

Effective Date: April 14, 2013

ACKNOWLEDGEMENT OF RECEIPT OF TUSCARAWAS COUNTY HEALTH DEPARTMENT NOTICE OF PRIVACY PRACTICES

On this date_____, I,_____(print name) have been given a copy of the *Notice of Privacy Practices* and a will be provided a new one if there is a change in the NOPP in the future. I have been offered and/or received a copy of the *Notice of Privacy Practices* confirmed by my signature below.

_____ _____

Patient Printed Name Date

_____

Patient/ Authorized Representative Signature

CONTACT INFORMATION

To provide the best care to you and in order to protect your confidentiality, please provide a way we may contact you.

I,_____(print name), authorize the Tuscarawas County Health Department to contact me in the following manner as indicated by my initials and signature at the bottom:

Location	**Number**	**Detailed Message (Y/N)**	**Call Back Message Only (Y/N)**	**Initial To Indicate Permission**
Home Phone				
Cell Phone				
Work Phone				

I understand if I have checked the box ***Detailed Message***, I agree TCHD may leave any of the following information in the message: appointment reminders, insurance/financial issues, and/or any other information regarding my care/treatment.

For ***Call Back Message Only*** may we identify ourselves at the Tuscarawas County Health Department?_____YES ____NO

If we mail information to you at the address provided above, which do you prefer:
___TCHD logo on envelope and letterhead____Plain envelope and letterhead

_____ _____

Patient/ Authorized Representative Signature Date

_____ _____

Witness Signature Date