

NOTICE OF HIPAA PRIVACY PRACTICES POLICY

In accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, As Amended

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

WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

We are legally required to protect the privacy of your health information. We call this information “protected health information,” or “PHI”, for short. It includes information that can be used to identify you and that we’ve created or received about your past, present, or future health condition, the provision of health care to you, or the payment for this health care. We are required to provide you with this notice about our privacy practices. It explains how, when, and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this notice.

- We reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the PHI we already have. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

We use and disclose health information for many different reasons. For some of these uses or disclosures, we need your specific authorization. Below, we describe the different categories of uses and disclosures.

Uses and Disclosures Which Do Not Require Your Authorization

- For treatment. We may disclose your PHI to hospitals, physicians, nurses, and other health care personnel in order to provide, coordinate or manage your health care or any related services.
- For payment. We may use and disclose your PHI for payment purposes.
- For health care operations. We may use and disclose your PHI for our health care operations as necessary, and as permitted by law. This might include measuring and improving quality, evaluating the performances of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

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- When a disclosure is required by federal, state or local law, judicial or administrative proceedings, or law enforcement. For example, we may disclose PHI when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence, when dealing with gunshot or other wounds, for the purpose of identifying or locating a suspect, fugitive, material witness or missing person; or when subpoenaed or ordered in a judicial or administrative proceeding.
- For public health activities. For example, we may disclose PHI to report information about births, deaths, various diseases, adverse events and product defects to government officials in charge of collecting that information; to prevent, control, or report disease, injury or disability as permitted by law; to conduct public health surveillance, investigations and interventions as permitted or required by law; or to notify a person who has been exposed to a communicable disease or who may be at risk of contacting or spreading a disease as authorized by law.
- For health oversight activities. For example, we may disclose PHI to assist the government or other health oversight agency with activities including audits, civil, administrative, or criminal investigations, proceedings or actions; or other activities necessary for appropriate oversight as authorized by law.
- To coroners, funeral directors, and for organ donation. We may disclose PHI to organ procurement organizations to assist them in organ, eye, or tissue donations and transplants. We may also provide coroners, medical examiners, and funeral directors necessary PHI relating to an individual's death.
- For research purposes. In certain circumstances, we may provide PHI in order to conduct medical research.
- To avoid harm. In order to avoid a serious threat to the health or safety of you, another person, or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen harm,
- For specific government functions. We may disclose PHI of military personnel and veterans in certain situations and we may also disclose PHI for national security and intelligence activities.
- For workers' compensation purposes. We may provide PHI in order to comply with workers' compensation laws.
- **HIV-related information, genetic information, alcohol and /or substance abuse records, mental health records and other specially Protected Health Information may enjoy certain special confidentiality protections**

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under applicable state and federal law. Any disclosures of these types of records will be subject to these special protections.

Uses and Disclosures Where You to Have the Opportunity to Object

We may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited Protected Health Information without your approval.

All Other Uses and Disclosures Require Your Prior Written Authorization. Other than as stated above, we will not disclose your PHI without your written authorization. You can later revoke your authorization in writing except to the extent that we have taken action in reliance upon authorization.

WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

You have the following right with respect to your PHI:

- **The Right to Request Limits on Uses and Disclosures of Your PHI.** You have the right to request in writing that we limit how we use and disclose your PHI. You may not limit the uses and disclosures that we are legally required to make. We will consider your request but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations.
- **The Right to Choose How We Send PHI to You.** You have the right to ask that we send information to you at an alternate address or by alternate means (for example, via e-mail instead of regular mail, fax, etc.). We must agree to your request so long as we can easily provide it in the manner you requested.
- **The Right to See and Get Copies of Your PHI.** In most cases, you have the right to look at or get copies of your PHI we have, but you must make the request in writing. In certain situations, we may deny your request. If we do, we will tell you in writing our reasons for the denial and explain your right to have the denial reviewed. If you request a copy of your information, we may charge you a reasonable fee for the cost of copying, mailing, or other costs incurred by us in complying with your request.

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- **The Right to Get a List of the Disclosures We Have Made.** You have the right to get a list of instances in which we have disclosed your PHI. Requests must be made in writing and signed by you or your representative. The list will not include uses or disclosures made for purposes of treatment, payment, or health care operations, and other specified exceptions. The list also will not include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or prior to April 14th, 2003.
- **The Right to Correct or Update Your PHI.** If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request, in writing, that we correct the existing information. You must provide the request and your reason for the request in writing. We may deny your request if the PHI is correct and complete, not created by us, not allowed to be disclosed, or not part of our records. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted to change. If we accept your request to change the information, we will make a reasonable effort to tell others, including people you name, of the change and to include the changes in any future sharing of that information.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice or any complaints about our privacy practices, please file a complaint with the person listed below. If you wish to also submit a written complaint to the U.S. Department of Health and Human Services, we will provide you with the address. Please contact the Human Resource Director, Centenary College, 400 Jefferson Street, Hackettstown, NJ 07840 or call 908-852-1400 ext.2268. We will not retaliate in any way if you choose to file a complaint.

EFFECTIVE DATE OF THIS NOTICE

This notice is effective as of April 14, 2004.

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HEALTH SERVICES DEPARTMENT

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Printed Name _____ Date of Birth _____

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The following individual or organization is authorized to make the disclosure:

Address: _____

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

- Entire record
- Immunization record
- Billing records
- Other

4. I understand that the information in my record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual or organizations:

Address: _____

For the purpose of:

- Sharing with other health care providers
- My personnel records
- Other

6. I understand that I have a right to revoke this information at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Human Resource Director. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition _____. If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

7. I understand that authorizing the disclosures of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information I can contact the Human Resources Director.

Signature of Patient or Legal Representative

Date

If Signed by Legal Representative, Relationship to Patient

Signature of Witness

