

COUNTY OF EDDY 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.

If you have any questions about this Notice please contact the County Privacy Contact Person Debbie Penaluna

Eddy County is required by law to maintain the privacy of Protected Health Information (“PHI”) and to provide you with notice of your legal duties and privacy practices with respect to PHI. PHI is information that may identify you and that relates to your past, present or future physical or mental health or condition and related health services. This Notice of Privacy Practices (“Notice”) describes how we may use and disclose PHI to carry out our treatment, payment or health care operations and for other specified purposes that are permitted or required by law. The Notice also describes your rights with respect to your PHI. We are required to provide this Notice to you by the Health Insurance Portability and Accountability Act (“HIPPA”).

We are required to abide by the terms of this Notice. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next visit to our office.

1. Uses and Disclosure of Protected Health Information

Your protected health information may be used and disclosed by the Eddy County staff who are involved in your care and treatment for the purpose of providing health care services. Your PHI may also be used and disclosed to pay your Indigent Health Care (“IHC”) bills.

Following are examples of the types of uses and disclosures of your PHI that the County is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your PHI protected.

Payment: Your PHI will be used, as needed, to process claims to allow payment for your IHC claims. This may include certain activities that the IHC employees may undertake before they approve or pay for the health care services you have received, such as: making a determination of eligibility for indigent coverage for payment benefits; reviewing services provided to you for medical necessity and applicability to their regulations; and undertaking utilization review activities. For example, we may receive a bill from a third-party claims processor, etc., which includes information that identifies you, as well as your health care treatment received.

We will share your PHI with third-party “business associates” that perform various activities (e.g. billing, processing claims) for the county. Whenever an arrangement between our offices and a

business associate involves the disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your PHI.

Healthcare Operations: We may use or disclose, as-needed, your PHI in order to support the business activities necessary. These activities include, but are not limited to, quality assessment activities, employee review activities, training of employees, licensing, and conducting or arranging for other business activities.

For example, we may use your PHI to provide you with information about benefits available to you, and, in limited situations, about health-related products or services that may be of interest to you. In addition, we may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

Use and Disclosures of Protected Health Information Based upon Your Written Authorization

Other use and disclosure of your PHI will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that the County has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Authorization or Opportunity to Object

We may use and disclose your PHI in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your PHI. If you are not present or able to agree or object to the use or disclosure of all or part of your PHI, then the County may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object

We may use or disclose your PHI in the following situations without your authorization. These situations include:

Required By Law: We may use or disclose your PHI to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your PHI for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your

PHI, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your PHI, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose your PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil right laws.

Abuse or Neglect: We may disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your PHI to the governmental entity or agency authorized to receive such information if we believe that you have been a victim of abuse, neglect or domestic violence. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Legal Proceedings: We may disclose PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose PHI, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal and other processes required by law, (2) pertaining to victims of a crime, (3) suspicion that death has occurred as a result of criminal conduct, (4) in the event that a crime occurs on the premises of the County; and (5) medical emergency (not on County premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donations: We may disclose PHI to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose PHI to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties.

Research: We may disclose your PHI 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 PHI.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your PHI, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose PHI to individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your PHI to

authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: Your PHI may be disclosed by us as authorized to comply with workers' compensation laws and other similarly legally-established programs.

Inmates: We may use or disclose your PHI if you are an inmate of a correctional facility and the County or your physician created or received your protected health information in the course of providing care to you.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

2. Your Health Information Rights

Following is a statement of your rights with respect to your PHI and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of PHI about you that is contained in a designated record set for as long as we maintain the PHI. A fee will be charged for copies in accordance with our local ordinance. A "designated record set" contains medical and billing records and any other records that the County uses for making decisions about you.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to the law that prohibits access to PHI. Depending on the circumstances, a decision to deny access may be able to be reviewed. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Contact if you have questions about access to your medical records.

You have the right to request a restriction of your protected health information.

You have the right to request additional restrictions on our use or disclosure of your PHI by sending a written request to the Privacy Officer. We are not required to agree to those restrictions. We cannot agree to restrictions on uses or disclosures that are legally required, or which are necessary to administer our business. You may request a restriction by completing a form, which can be requested from the County representative.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.

You may have the right to have your physician amend your protected health information.

This means you may request an amendment of PHI about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with

a copy of any such rebuttal. Please contact our Privacy Contact to determine if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Contact of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Contact, Debbie Penaluna at 505-887-9511, or 101 W. Greene, Carlsbad, NM 88220 or email at debbie@co.eddy.nm.us for further information about the complaint process.

This notice is effective 4-13-03.

This Notice was given to me by _____ on _____.

Signature

Date

Printed Name

AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION

I, _____, hereby authorize the County of Eddy to (check those that apply):

_____ Use the following protected health information and/or

_____ Disclose the following protected health information to:

Name of Receiver: _____

Address of Receiver: _____

(Describe the information to be used or disclosed, including, but not limited to, descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc.)

This protected health information is being used or disclosed for the following purposes:

This authorization shall be in force and effect until _____, at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Ms. Debbie Penaluna Privacy Contact, County of Eddy, 101 W. Greene, Carlsbad, NM 88220, phone number 505-887-9511. I understand that a revocation is not effective to the extent that Eddy County has relied on the use or disclosure of the protected health information.

I understand that information is used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

The County of Eddy will not condition the treatment, payment, or eligibility for benefits on whether I provide authorization for the requested use or disclosure. I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- Refuse to sign this authorization.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal representative's Authority

REQUEST FOR CORRECTION/AMENDMENT OF HEALTH INFORMATION

Patient Name _____ Date of birth _____

Patient Number _____ Telephone _____

Date of entry to be amended _____ Type of entry to be amended _____

Please explain how the entry is incorrect or incomplete. What should the entry state in order to be more accurate or complete?

Would you like this amendment sent to anyone to whom we may have disclosed information in the past? If so, please specify the name and address of the organization or individual.

Signature of Patient or Legal Representative

Date

Comments of County employee:

Signature of County employee

Date

RECORD OF VERBAL DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____

Date of Birth: _____

Patient Number: _____

Date of Disclosure: _____

Time of Disclosure: _____

Information Disclosed to:

Name: _____

Address: _____

Telephone Number: _____

Reason for disclosure: _____

Specific Information disclosed:

Signature of Individual Making Disclosure

Date

REVOCAION OF AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

1. I hereby revoke authorization to the County of Eddy to disclose information from the health records of:

Patient Name: _____ Date of Birth: _____

Address: _____

Telephone: _____

Patient number: _____

Covering the period(s) of health care:

From (date) _____ to (date) _____

2. I understand that disclosures made in good faith may have already occurred in reliance upon my previously issued authorization and that this revocation cannot apply retroactively to such disclosures. I also understand that the disclosure of health information may be required by law in some instances, such as for the reporting of communicable diseases.

3. The County of Eddy, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the information I authorized previously.

Signed: _____

Signature of Patient or Legal Representative

Date

Signature of Witness

Date