

**Part 6 (4 pages)**

**NOTICE OF PRIVACY PRACTICES RECEIPT  
HACKENSACK UNIVERSITY MEDICAL CENTER**

MRN# \_\_\_\_\_

I,  acknowledge receiving the Hackensack University Medical Center

(HUMC) Notice of Privacy Practices. I also acknowledge that future revisions of this notice will be available on the

HUMC website [www.HackensackUMC.org](http://www.HackensackUMC.org) or upon request.

This pertains to the **HIPAA-NOTICE OF PRIVACY ACT GUIDELINES**. I have received the privacy act guidelines pamphlet and listed all family members who can actively participate in my care planning. I understand that if I do not list these individuals, my patient information or the planning of my care will not be released or planned without my consent.

<input type="text"/>	<input type="text"/>	relationship	<input type="text"/>	Phone #
<input type="text"/>	<input type="text"/>	relationship	<input type="text"/>	Phone #
<input type="text"/>	<input type="text"/>	relationship	<input type="text"/>	Phone #

Signature: X

Date signed:

Hospital Witness Name (print)

Witness Signature: X

Date signed:

# Hackensack University Medical Group

## HIPAA Notice of Privacy Practices

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS YOUR INFORMATION. PLEASE REVIEW CAREFULLY.**

### OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

### HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

**For Treatment.** We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

**For Payment.** We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

**For Health Care Operations.** We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

**Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services.** We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

**Individuals Involved in Your Care or Payment for Your Care.** When appropriate, and unless you object, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort. 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.

**Research.** Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

### SPECIAL SITUATIONS:

**As Required by Law.** We will disclose Health Information when required to do so by international, federal, state or local law.

**To Avert a Serious Threat to Health or Safety.** We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

**Business Associates.** We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

**Organ and Tissue Donation** . If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

**Psychotherapy Notes:** Any disclosure of Psychotherapy notes as defined in 45 CFR 164.501 will required your authorization.

**Workers' Compensation.** We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

**Public Health Risks.** We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

**Health Oversight Activities** . We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

**Law Enforcement.** We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

**Coroners, Medical Examiners and Funeral Directors.** We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

**Inmates:** If you are an inmate of a correctional institution, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

**Fundraising:** We may contact you as part of a fundraising effort. The information used for this purposes will not disclose any health condition, but may include your name, address, phone number, email address, etc. When contacted you may ask that we stop any future fundraising requests.

**Marketing:** Most of the uses and disclosures for marketing purposes, including subsidized treatment communications will require your authorization. In addition, most of the disclosures of your information that constitutes the sale of the information will require your authorization. We will obtain your authorization for any other use of your identifiable image that is unrelated to treatment, payment or health care operations.

#### **WHEN WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES**

Uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

#### **YOUR RIGHTS:**

You have the following rights regarding Health Information we have about you:

**Right to Inspect and Copy.** You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to the practice location where your care was provided. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

**Right to an Electronic Copy of Electronic Medical Records.** If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that

an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

**Right to Notification of a Breach.** You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

**Right to Amend .** If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to the practice location where your care was provided.

**Right to an Accounting of Disclosures.** You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment , payment and health care operations or for wh ich you provided written authorization. To request an accounting of disclosures, you must make your request , in writing, to the practice location whe re your care was provided.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend.

For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to the practice location where your care was provided. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket " in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

**Restriction on Service Paid Out-of-Pocket.** If you paid out-of-pocket (or in other words, you have requeste'd that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

**Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to the practice location where your care was provided . Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

**Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a

paper copy of this notice. You may obtain a copy of this notice at our web site, [www.HackensackUMG.com](http://www.HackensackUMG.com). To obtain a paper copy of this notice please contact the Corporate Compliance Department at 551-996-4205

#### **CHANGES TO THIS NOTICE:**

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office and on our web site [www.HackensackUMG.com](http://www.HackensackUMG.com). The notice will contain the effective date on bottom of the last page..

#### **For More Information or To Report a Problem**

If have questions and would like additional information, you may contact the Office of Patient Experience at 551-996- 2010 . If you believe your privacy rights have been violated, you can file a complaint with the Administrative Director of Service Excellence 551-996-2010 or directly with the Secretary of Health and Human Services in Washington (1-877-696- 6775). There will be no retaliation for filing a complaint.

Effective Date: 9/15/2013