

Effective date of Notice: September 23, 2013

NOTICE OF PRIVACY PRACTICES

HealthSource Saginaw, Inc.
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Contact: Karen Gregg, RHIA, CHPS

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

We respect our legal obligation to keep personal and health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your information and what rights you have regarding your information. If you have any questions about this Notice, please contact the contact person shown above.

USES AND DISCLOSURES WITHOUT YOUR PERMISSION

We may disclose your information for certain purposes without your authorization, including the following:

Treatment, Payment and Health Care Operations. The most common reason why we use or disclose your health information is for treatment, payment or health care operations.

Treatment: We may use or disclose your information to treat you. For example, we may use or disclose your information to schedule an appointment for you; perform a physical examination; perform diagnostic tests; prescribe medications and fax or send them electronically to be filled; refer you to another health care provider for additional or specialist services; or get copies of your health information from another health care provider that you may have seen before.

Payment: We may use or disclose your information to obtain payment for the services we provide to you. For example, we may use or disclose your information to ask you or your insurance company about your health insurance coverage or other sources of payment; to prepare and send bills or claims; or to collect unpaid amounts (either ourselves or through a collection agency or attorney).

Health Care Operations: We may use or disclose your information for certain administrative and managerial activities that are necessary for us to run our business. For example, we may use or disclose your information to train or evaluate our staff; to conduct financial or billing audits; to conduct internal quality assurance; to participate in managed care plans; to defend legal matters; to conduct business planning; or to contract for storage of our records.

Disclosures Unless You Object. Unless you instruct us not to, we may release health information about you to (1) a friend, family member or other person who is involved in your medical care, (2) to maintain our facility directory, and (3) to contact you to raise funds for HealthSource Saginaw, Inc. You may opt out of receiving such notifications at any time by notifying the contact person named at the beginning of this Notice.

Other Uses and Disclosures

In some limited situations and if certain conditions are satisfied, we may also use or disclose your information without your permission. Not all of these situations will apply to us; some may never occur at all. Such uses or disclosures are:

when a state or federal law mandates that certain health information be reported for a specific purpose;

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for public health purposes, such as contagious disease reporting, investigation or surveillance, and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;

to governmental authorities about victims of suspected abuse, neglect or domestic violence;

for health oversight activities, such as for the licensing of doctors, for audits by Medicare or Medicaid, or for investigation of possible violations of health care laws;

for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;

for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime, to report or provide information about a crime;

to a medical examiner to identify a dead person or to determine the cause of death, or to funeral directors to aid in burial, or to organizations that handle organ or tissue donations;

for health related research;

to prevent a serious threat to health or safety;

for specialized government functions, such as for the protection of the president or high ranking government officials, for lawful national intelligence activities, for military purposes, or for the evaluation and health of members of the foreign service;

disclosures of de-identified information;

disclosures relating to worker's compensation programs;

disclosures of a "limited data set" for research, public health, or health care operations;

incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;

disclosures to "business associates" who perform health care operations for us and who agree to comply with privacy and security laws and regulations that apply to them; and

APPOINTMENT REMINDERS

We may call, write or E-mail to remind you of scheduled appointments or the need to make a routine appointment. We may also call, write, or E-mail to notify you of other treatments or services available that might help you.

USES AND DISCLOSURES WITH YOUR PERMISSION

We will not make any other uses or disclosures of your information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it is your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign the authorization, you may revoke it at any time unless we have already acted in reliance upon it. Your revocation of authorization must be in writing and sent to the contact person named at the beginning of this Notice.

We will request your authorization before disclosing any information relating to treatment for mental health or substance abuse or HIV or AIDs.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can request any of the following rights by sending a written request to the contact person named at the beginning of this Notice:

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ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want.

ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E-mail to your personal E-mail address. We will accommodate these requests if they are reasonable and if you pay us for any extra cost.

ask to see or to get photocopies of your health information. Generally, except in a few limited situations, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension.

ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information and others that you specify. If we do not agree, you can write a statement of your position and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension.

get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures that were made with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing.

get additional paper copies of this Notice of Privacy Practices upon request.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices. We reserve the right to change this Notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to all health information that we maintain. If we change our Notice of Privacy Practices, we will post the new Notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or to the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the contact person at the address, fax or E-mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the contact person at the address or phone number shown at the beginning of this Notice.

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HealthSource Saginaw, Inc.

**Health Insurance Portability and Accountability Act (HIPAA)
ACKNOWLEDGMENT
RECEIPT OF NOTICE OF PRIVACY PRACTICES**

By signing below, I acknowledge that I have received the Notice of Privacy Practices from HealthSource Saginaw, Inc.

Patient/Resident/Guardian Signature

Date

Witness Signature

Date

Documentation of Failure to Obtain Signed Acknowledgment

On _____, presented its Acknowledgment of Receipt of Notice of Privacy Practices Form to _____. The patient refused or was unable to provide a signature when requested.

ADDRESSOGRAPH