

## **NOTICE OF PRIVACY PRACTICES**

### **Fulton County Health Department**

**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.**

The Fulton County Health Department (HD) obtains medical information about you in treating you. This medical information is called “protected health information” or “PHI”. Your PHI is used by HD to treat you. For example, we refer to PHI in treating you at the health department. We may also send your PHI to another physician or counselor to which we refer you.

The HD also uses your PHI to obtain payment for the services we render. For example, we send PHI to Medicaid, Medicare, or your insurance plan to obtain payment for our services.

The HD uses your PHI for operations of the health department. For example, we may use your PHI in determining whether we are giving adequate treatment to our clients.

We are required by federal and state law to maintain the privacy of your PHI. We are also required by law to provide you with this Notice of our legal duties and privacy practices. In addition, the law requires us to ask you to sign an Acknowledgment that you received this Notice.

**This is a list of some of the types of uses and disclosures of PHI that may occur:**

**Treatment:** We obtain medical information about you in treating you. This medical information is called “protected health information” or “PHI”. Your PHI is used by us to treat you. For example, we refer to PHI in treating you at the health department. We may also send your PHI to another physician or counselor to which we refer you for treatment. We may also use your PHI to contact you to tell you about alternative treatments, or other health-related benefits we offer. If you have a friend or family member involved in your care, we may give them PHI about you.

**Payment:** We use your PHI to obtain payment for the services that we render. For example, we send PHI to Medicaid, Medicare, or your insurance plan to obtain payment for our services.

**Health Care Operations:** We use your PHI for our operations. For example, we may use your PHI in determining whether we are giving adequate treatment to our clients. From time-to-time, we may use your PHI to contact you to remind you of an appointment.

**Legal Requirements:** We may use and disclose your PHI as required or authorized by law. For example, we may use or disclose your PHI for the following reasons:

**Public Health:** We may use and disclose your health care information to prevent or control disease, injury or disability, to report births and deaths, to report reactions to medicines or medical devices, to notify a person who may have been exposed to a disease, or to report suspected cases of abuse, neglect or domestic violence.

**Health Oversight Activities:** We may use and disclose your PHI to state agencies and federal government authorities when required to do so. We may use and disclose your health information in order to determine your eligibility for public benefit programs and to coordinate delivery of those programs. For example, we must give PHI to the Secretary of Health and Human Services in an investigation into our compliance with the federal privacy rule.

**Judicial and Administrative proceedings:** We may use and disclose your PHI in judicial and administrative proceedings. Efforts may be made to contact you prior to a disclosure of your PHI by the party seeking the information.

**Law Enforcement:** We may use and disclose your PHI in order to comply with requests pursuant to a court order, warrant, subpoena, summons, or similar process. We may use and disclose PHI to locate someone who is missing, to identify a crime victim, to report a death, to report criminal activity at our offices, or in an emergency.

**Avert a Serious Threat to Health or Safety:** We may use or disclose your PHI to stop you or someone else from getting hurt.

**Work-Related Injuries:** We may use or disclose PHI to an employer if the employer is conducting medical workplace surveillance or to evaluate work-related injuries.

**Coroners, Medical Examiners, and Funeral Directors:** We may use or disclose PHI to a coroner or medical examiner in some situations. For example, PHI may be needed to identify a deceased person or determine a cause of death. Funeral directors may need PHI to carry out their duties.

**Armed Forces:** We may use or disclose the PHI of Armed Forces personnel to the military for proper execution of a military mission. We may also use and disclose PHI to the Department of Veterans Affairs to determine eligibility for benefits.

**National Security and Intelligence:** We may use or disclose PHI to maintain the safety of the President or other protected officials. We may use or disclose PHI for the conduct of national intelligence activities.

**Correctional institutions and custodial situations:** We may use or disclose PHI to correctional institutions or law enforcement custodians for the safety of individuals at the correctional institution, those that are responsible for transporting inmates, and others.

**Research:** You will need to sign an Authorization form before we use or disclosure PHI for research purposes except in limited situations. For example, if you want to participate in research or a clinical study, an Authorization form must be signed.

**Fundraising:** If we undertake any fundraising activities, we may contact you about the fundraising activity. We do not engage in marketing activities, and need your authorization to do so.

**Illinois law:** Illinois law also has certain requirements that govern the use or disclosure of your PHI. In order for us to release information about mental health treatment, genetic information, your AIDS/HIV status, and alcohol or drug abuse treatment, you will be required to sign an authorization form unless state law allows us to make the specific type of use or disclosure without your authorization.

**Your Rights:** You have certain rights under federal privacy laws relating to your PHI. Some of these rights are described below:

**Restrictions:** You have a right to request restrictions on how your PHI is used for purposes of treatment, payment and health care operations. We are not required to agree to your request.

**Communications:** You have a right to receive confidential communications about your PHI. For example, you may request that we only call you at home. If your request is reasonable, we will accommodate it.

**Inspect and Access:** You have a right to inspect information used to make decisions about your care. This information includes billing and medical record information. You may not inspect your record in some cases. If your request to inspect your record is denied, we will send you a letter letting you know why and explaining your options.

You may copy your PHI in most situations. If you request a copy of your PHI, we may charge you a fee for making the copies and mailing them to you, if you ask us to mail them.

**Amendments of your Records:** If you believe there is an error in your PHI, you have a right to request that we amend your PHI. We are not required to agree with your request to amend.

**Accounting of Disclosures:** You have a right to receive an accounting of disclosures that we have made of your PHI for purposes other than treatment, payment, and health care operations, or release made pursuant to your authorization.

**Copy of Notice:** You have a right to obtain a paper copy of this Notice, even if you originally received the Notice electronically. We have also posted this Notice at the health department offices.

**Complaints:** If you feel that your privacy rights have been violated, you may file a complaint with the health department by calling our Privacy Officer at (309)647-1134. We will not retaliate against you for filing a complaint. You may also file a complaint with the Secretary of Health and Human Services in Washington, DC if you feel your privacy rights have been violated.

We maintain a facility directory so that if family or friends ask us about your condition, we can tell them general information and the fact that you are here. If you do not want us to tell anyone you are here, please tell us now.

We are required to abide with terms of the Notice currently in effect, however, we may change this Notice. If we materially change this Notice, you can get a revised Notice on our website at [www.fultoncountyhealth.com](http://www.fultoncountyhealth.com) or by stopping by our office to pick up a copy. Changes to the Notice are applicable to the health information we already have.

If we seek help from individuals or entities who are not part of this Notice in our treatment, payment, or health care operations activities, we will require the those persons to follow this Notice unless they are already required by law to follow the federal privacy rule.

**EFFECTIVE DATE: April 14, 2003**

**CONSENT and ACKNOWLEDGMENT**  
**Receipt of Notice of Privacy Practices**

I, \_\_\_\_\_ hereby acknowledge that I received the  
(print name of client)  
“Notice of Privacy Practices” from the Fulton County Health Department dated April 14, 2003.

I understand that the health department is already authorized to use the information gained during treatment to bill me, my insurance company, or any other potential sources of reimbursement, such as government programs in which I am enrolled or qualify for services.

\_\_\_\_\_  
Signed

\_\_\_\_\_  
Date

Check if any of the following apply:

- |  |   |
|--|---|
| <input type="checkbox"/> Parent or Guardian of minor                       | <input type="checkbox"/> Health Care Surrogate                                |
| <input type="checkbox"/> Power of Attorney for Health Care                 | <input type="checkbox"/> Mental Health Treatment Preference Declaration Agent |
| <input type="checkbox"/> Guardian with power to make health care decisions |   |

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**FOR STAFF USE ONLY:**

**I attempted to obtain an Acknowledgment of the Receipt of the Notice of Privacy Practices on behalf of the HD. The HD was unable to obtain the Acknowledgment because:**

- Client refuses to sign       Other (specify): \_\_\_\_\_

\_\_\_\_\_(Staff member's initials)

\_\_\_\_\_(Date)

(Staff: Place Acknowledgment in patient's medical record.)