

OUR PRIVACY RESPONSIBILITIES UNDER HIPAA

Minnesota law requires that all Health Care Providers protect health records in our possession. If you receive services through First Choice Clinic, federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), also protects your health information. In addition, HIPAA requires that we provide you this Notice of Privacy Rights. It lets you know how we may use and disclose your health information and your rights regarding the health information we have in our possession.

HEALTH INFORMATION THAT WE MAINTAIN ABOUT YOU

We maintain records of:

- Your name and (if different) the name and relationship of the person receiving Treatment
- Your billing address
- Your telephone number
- Your (or the patient's, if different) condition that brings you here to First Choice Clinic
- The date the doctor reviewed your chart with you.
- Clinical findings related to the condition such as results of blood tests, EKG's , Pregnancy Tests, Glucose Tests and any other diagnostic or monitoring test to ensure your safety

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the right to:

- request restrictions on certain uses and disclosures
- receive communications of protected health information by alternative means or at alternative locations
- inspect, copy and amend your protected health information held at First Choice Clinic
- receive an accounting of certain disclosures (of your protected health information)
- receive a paper copy of this notice even if you have received it electronically

HOW WE USE AND DISCLOSE YOUR HEALTH INFORMATION

We only use or disclose your health information as state and federal laws require or permit. In some cases, the law requires that you authorize the disclosure. In other cases, the law allows us to disclose your health information without your authorization.

Use and Disclosure Not Requiring Your Authorization

Treatment: We may use your health information for our treatment activities, such as disclosing it to other healthcare providers as helpful to treat you.

Payment: We may use and disclose your health information for our payment and collection activities, such as sending claims to insurance companies for the payment of certain covered medical services that First Choice Clinic may provide.

Healthcare Operations: We may use and disclose your health information to manage our program operations, such as reviewing the quality of services you receive.

Business Associates: We may disclose your health information to organizations that help us with our work, such as the billing service we use to process claims to your health insurance company. We have a written agreement that requires these organizations to use your health information for only the reasons necessary to do the work, and protect it from other uses or disclosures, just like we do.

To Contact You

We may use the information in your health records to contact you if we have information about treatment or other health-related benefits and services that may be of interest to you.

Other Permitted Uses and Disclosures

HIPAA specifically permits us to use or disclose your health information for other purposes without your consent or authorization. In our experience such disclosures are rare, and the limited information we maintain is generally not applicable. However, when authorized by law, and to the extent we may have the information, HIPAA permits us to disclose it to:

- comply with the requirements of federal, state, or local laws, court orders or other lawful process and for administrative or court proceedings
- report a public health authority for the purpose of preventing or controlling disease, injury, or disability
- report to the FDA for the quality, safety or effectiveness of FDA-regulated products or activities
- notify a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition
- report abuse, neglect or domestic violence to a government authority
- provide necessary information to a health oversight agency for activities such as audits, investigations, inspections, licensure of the healthcare system, government benefit programs and regulated entities
- a law enforcement official for specified law enforcement purposes
- coroners or medical examiners for identification or determining cause of death
- funeral directors to carry out their duties with respect to the decedent
- organ procurement organizations for facilitating donation and transplantation
- researchers conducting studies approved by an Institutional Review Board
- prevent or lessen a serious and imminent threat to the health of safety of a person or the public
- authorized federal officials for specialized government functions such as military and veterans activities; national security and intelligence activities; protective services for the president; medical suitability determinations; correctional institutions; government entities providing public benefits and
- comply with workers' compensation laws

Uses and Disclosures with Your Authorization

Other uses and disclosures of your personal information require your written authorization. You may revoke your authorization at any time by doing so in writing.

HOW YOU CAN REACH US

If you want additional information about our privacy practices or if you believe the First Choice Clinic has violated your privacy rights, you may file a complaint by contacting the HIPAA Privacy/Compliance Officer at:

First Choice Clinic
1755 Old West Main Street Suite 101
Red Wing, MN 55066.

First Choice Clinic does not retaliate against people who file a complaint.

Additional Protections for Certain Information

- Confidential HIV related Information for which additional protections are provided by state law
- Alcohol or Substance Abuse Treatment Information for which additional protections are provided by state law
- Mental Health Treatment information for which additional protections are provided by state law.

CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION *

Use and disclosure of your protected health information will be used by First Choice Clinic or disclosed to others for the purposes of treatment or supporting the day-to-day health care operations of the organization.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information.

First Choice Clinic may or may not agree to restrict the use on disclosure of your protected health information.

If First Choice Clinic agrees to your request, the restriction will be binding on the Clinic. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices

First Choice Clinic reserves the right to modify the privacy practices outlined in the notice.

Signature

I have reviewed this consent form and give my permission to First Choice Clinic to use and disclose my health information in accordance with the Notice of Privacy Practices.

Date: _____

Name of Client (Print or Type): _____

Signature of Client: _____

Signature of Client Representative: _____

Relationship of Client Representative to Client: _____

If you do not want to participate in fund raising efforts, please check off the following box.

Please do not use my information for fund raising purposes.

Internal Use Only

If patient/patient's representative refuses to sign acknowledgment, please document date and time notice was presented to patient and sign below.

Presented on (Date): _____ Time: _____ (circle) a.m. p.m.

By (Name and Title): _____

**(to be filed in patient's health record*