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.

YOU HAVE THE RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE UPON REQUEST.

This Notice describes the privacy practices of the Metro Nashville Public Health Clinics, including the Lentz Public Health Center, East Public Health Center, and Woodbine Public Health Center.

Patient Health Information

Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How We Use Your Patient Health Information

We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.

Examples of Treatment, Payment, and Health Care Operations

Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.

Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.

Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

Special Uses

We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Uses and Disclosures

We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:

- *Required by Law:* We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
- *Public Health Activities:* As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities, including other departments within the Metropolitan Nashville Health Department.
- *Health Oversight:* We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
- *Judicial and Administrative Proceedings:* We may disclose information in response to an appropriate subpoena or court order.

(Continued on Page 2)

- *Law Enforcement Purposes:* Subject to certain restrictions, we may disclose information required by law enforcement officials.

- *Deaths:* We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.

- *Serious Threat to Health or Safety:* We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

- *Military and Special Government Functions*: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.

- *Research:* We may use or disclose information for approved medical research.

- *Individuals Involved in Your Care*: We may provide information about you to a family member, friend, or other person involved in your health care or in payment for your health care. If you are deceased, we may disclose medical information about you to a friend or family member who was involved in your medical care prior to your death, limited to information relevant to that person's involvement, unless doing so would be inconsistent with wishes you expressed to us during your life. We will ask you to complete a form to help clarify for us which of your family members and/or friends are likely to be involved with your health care and/or payment for your health care. If we disclose information to a family member, relative or close personal friend, we will disclose only information that we believe is relevant to that person's involvement with your health care or payment related to your health care.

- *Notification and Disaster Relief*: We may use or disclose your health information to notify or assist in notifying your family, a personal representative, or another person responsible for your care, of your location, condition, or death. We may disclose your health information to disaster relief authorities so that your family can be notified of your location and condition.

- *Business Associates*: We may contract with one or more third parties (our business associates) in the course of our business operations. We may disclose your health information to our business associates so that they can perform the job we have asked them to do. We require that our business associates sign a business associate agreement and agree to safeguard the privacy and security of your health information.

- *Workers Compensation:* We may release information about you to workers compensation agencies and your employer to provide benefits for work-related injuries or illness.

Authorizations for Other Uses and Disclosures

While we may use or disclose your health information without your written authorization as explained above, there are other instances where we will obtain your written authorization. Except as otherwise provided in this Notice, we will not use or disclose your health information without your prior written authorization. You may revoke an authorization at any time, except to the extent we have already relied on the authorization and taken action.

Examples of uses and disclosures that require your authorization are:

- Most uses and disclosures of psychotherapy notes (if recorded by a covered entity) will require your written authorization.

- Most uses and disclosures for marketing purposes, including subsidized treatment communications, will require your written authorization.

- Most disclosures of PHI that constitute the sale of PHI will require your written authorization.

- We will not sell your health information to a third party without your prior authorization.

In any other situation, not covered in this NPP, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

(Continued on page 3)

Individual Rights

You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.

Request Restrictions: You have the right to request restrictions on health information disclosures to your health plan for health services or items paid out-of-pocket in full, and we (the covered entity) must comply with such a request.

Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.

Inspect and Obtain Copies: In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies.

All requests to inspect or copy your health information must be in writing. We can provide a form for you to use. In certain circumstances, we may deny your requests, but if we do, we will notify you in writing of the reason(s) for the denial and explain your right to have the denial reviewed. If the information is maintained electronically and if you request an electronic copy, we will provide you with an electronic copy in the form or format requested by you, if it is readily producible in the form or format (if it is not, then we will agree with you on a readable electronic form and format). You can direct us to transmit the copy directly to another person if you submit a signed written request that identifies the person to whom you want the copy sent and where to send it. If you request copies, we may charge a reasonable cost-based for the labor involved in copying the information, the supplies for creating the paper copy or the cost of the portable media, postage, and providing a summary of your records, if you request a summary.

Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to submit a written request that we correct the existing information or add the missing information. We may deny your request and if we do, we will notify you in writing of the reason for the denial and your right to submit a statement disagreeing with the denial.

Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations. Your request must be in writing and we can give you a form. The first disclosure list in a year is free; if you request additional lists in any year we may charge you a fee.

Fundraising: Although seriously unlikely, you may be contacted for fundraising purposes; however, you have the right to opt out of such fundraising communications with each solicitation.

Breach Notification: You will receive notification of any breach of your unsecured PHI

Privacy Notice Copy: You may obtain a paper copy of this Notice upon request. You may obtain a paper copy of this Notice by visiting our medical facility. The Notice is also available on our website.

Our Legal Duty

We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.

Changes in Privacy Practices

We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints

If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person

If you have any questions, requests, or complaints, please contact:

Name:	Tonya Foreman
Title:	Privacy Officer, MPHD
Address:	2500 Charlotte Avenue, Nashville, TN 37209
Phone Number:	(615) 340-5677
Fax:	(615) 340-8565
E-Mail:	tonya.foreman@nashville.gov

(Effective Date: 12/2/2014, Rev: 4/15/2013, 8/28/2014, 5/20/2015)

Metro Public Health Dept
Nashville/Davidson County
Protecting, Improving, and Sustaining Health

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I, _________________________________ , hereby acknowledge receipt of the Notice of Privacy Practices given to me by the Clinic.

Signed: ____ Date: __________________________

* *

For Office Use Only:

Name of Clinic: ____

Person seeking acknowledgement: _____________________________ *Date:*__________________

If not signed, document good faith efforts to obtain acknowledgment: ____________________________

____

____

____

____