# VillageHealth Consent Selections

Please complete the form and return to us. Questions? Call us at 1-800-767-0063

The following documentation details the permissions granted to VillageHealth*. Please review the attached documents prior to completing this form if you have not done so already. Additional information regarding these consent selections can be found in the attached documents. You may change these selections and/or revoke your consent by speaking with your care team and requesting a new form to complete. Otherwise, these permissions will remain in place for the duration of your treatment, unless otherwise noted.

**Consent to View Health Information from Shared Electronic Databases** – VillageHealth utilizes shared digital health information databases through which we are able to access your health records from other providers. Additional information regarding our access to these databases can be found in the attached. Please select an option below:

☐ I GIVE CONSENT for VillageHealth to access and share my health information through the shared external electronic databases described in the attached form for any permitted healthcare purpose.

☐ I DO NOT GIVE CONSENT for VillageHealth to access and share my health information through the shared external electronic databases described in the attached form for any permitted healthcare purpose.

**Digital Communication** – You can make your selections for digital communication preferences below. You are responsible for the security of your personal email account and phone. You agree to notify VillageHealth as soon as possible of any changes to your contact information. Please note that digital communications are not guaranteed secure. They are easier to intercept than standard mail and you should make yourself familiar with the associated risks before making these selections.

**Email Address:** _____

**Phone:** _____ **Mobile:** _____

**By checking the boxes below, you agree to periodic communications from VillageHealth via the methods selected.**

☐ **Detailed Voicemails**
(Detailed voicemails may include sensitive health information)

☐ **General Text Message Communications**
(Appointment Reminders; General Updates; Educational Materials; Etc.)

☐ **Marketing Text Message Communications**

☐ **General Email Communications**
(Appointment Reminders; General Updates; Educational Materials; Etc.)

☐ **Marketing Email Communications**

**Notice of Privacy Practices** – By signing below you acknowledge that you have received our Notice of Privacy Practices detailing our use, access, and storage of your personal health information. By signing below, you attest that you have reviewed the terms and conditions set out in the corresponding documents and give your informed consent to the terms and conditions as they relate to your health information and communication preferences.

_____ _____

Patient Name (Print) Patient Date of Birth

_____ _____

Patient or Personal Representative Signature Date

☐ I am signing this form on behalf of a patient. I represent that I am the legal parent/guardian/personal representative of the patient named above. *(Proof of legal representation is required if you are acting as a personal representative or court appointed guardian).*

# Consent to Release Protected Health Information

Please complete the form and return to us. Questions? Call us at 1-800-767-0063

1. **PATIENT NAME (Last, First, MI):**_____ DOB: ____/____/____

2. I consent to the release of any and all of my health information by any health care professional or health care entity to VillageHealth*, for review and/or copy.

3. I consent to the release of any and all of my health information held by VillageHealth to my other health care providers with whom I have a treating relationship for care collaboration with VillageHealth. However, I do NOT consent to the release of information regarding the following health conditions from VillageHealth:

   ☐ HIV/AIDS

   ☐ Sickle Cell Anemia

   ☐ Mental Health

   ☐ Substance Abuse

4. I understand that the information will be shared for continuing medical care under VillageHealth's disease management program.

5. This consent will expire 10 years from the date of signature. You can revoke this consent by writing to your VillageHealth care team or the Privacy Office at privacy@davita.com. A photocopy is as valid as the original.

_____ _____

Patient Name (Print) Patient Date of Birth

_____ _____

Patient or Personal Representative Signature Date

☐ I am signing this form on behalf of a patient. I represent that I am the legal parent/guardian/personal representative of the patient named above. *(Proof of legal representation is required if you are acting as a personal representative or court appointed guardian).*

# Permission to Discuss Health Information with Other Individuals

Please complete the form and return to us. Questions? Call us at 1-800-767-0063

If you would like to designate a family member or other individual that we may discuss your medical treatment, payment, and/or condition with, list them below including their name, relationship to you, and contact information.

I hereby grant VillageHealth*, its employees, subsidiaries, and affiliates, to discuss my health information with the following people as it relates to their involvement in my care or payment for health care services I receive:

| Name | Relationship | Phone Number |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |

I understand that VillageHealth may still share my information with my family and friends or others if I am incapacitated or not present and VillageHealth determines, that it is in my best interest or necessary for my care and/or payment for the health care services I have received. By completing this form, I revoke all previously completed permission to discuss forms.

**Disclosures**

You may revoke or change this list of people at any time by requesting and completing a new form or speaking with your care team. A revocation or change to this list is only effective in regard to future disclosures following the revocation or change. This authorization/permission form will remain in effect for ten (10) years, unless you live in Maine, in which case this form will expire in 30 months or Maryland, in which case, this form will expire in 1 year. In no circumstance will this form remain in effect after your treating relationship with VillageHealth has ended or you revoke this form.

_____ _____

Patient Name (Print) Patient Date of Birth

_____ _____

Patient or Personal Representative Signature Date

☐ I am signing this form on behalf of a patient. I represent that I am the legal parent/guardian/personal representative of the patient named above. (Proof of legal representation is required if you are acting as a personal representative or court appointed guardian).

# CONSENT TO VIEW HEALTH INFORMATION FROM SHARED ELECTRONIC EXTERNAL DATABASES TERMS & CONDITIONS

**PLEASE READ THESE DETAILS ABOUT THE SOURCES WHERE YOUR INFORMATION CAN BE GATHERED:**

**How your information may be used:** VillageHealth* participates in shared external electronic databases through which other providers share health information related to their patients. By accessing and sharing this information VillageHealth is able to provide you with more holistic healthcare. For any shared external electronic database for which you provide consent to access and share your health information, VillageHealth will use the health information for permitted health care purposes, such as for treatment, payment, or healthcare operations, including care coordination among my healthcare providers.

**What types of information about you are included?**

**Encounter Data:**
- Health history
- Treatment records
- Hospitalization records
- Test/Labs results
- Medication lists
- Outpatient care records

**Insurance Claims Data**
- Historical Claims
- Pending Claims
- Present Claims

**What information is not included? The following information will not be shared with the external databases.**

**Sensitive Information**
- Substance Abuse information
- Mental Health information
- Sickle Cell Anemia diagnoses and treatment
- Sexually transmitted disease information (including HIV/AIDS)
- Reproductive Health Information
- Genetic Testing Information
- Tuberculosis diagnoses and treatment
- Any other information that requires your subsequent consent to be disclosed

**Where health information about you comes from:** Information about you comes from places that have provided you with medical care or health insurance. These include, but are not limited to, hospitals, clinics, physicians, pharmacies, clinical laboratories, health insurers, state Medicaid program, Medicare, other governmental programs, and other organizations that exchange health information electronically.

**Uses and Disclosures Required by Law:** Even if I deny consent, or do not complete this consent form, several states still allow access to my health information as required by law, including for public health reporting or emergency purposes.

**Re-disclosure of information:** Any health information about you may be re-disclosed to others only to the extent permitted by state and federal laws and regulations. I understand that once my information is disclosed, it may be subject to lawful re-disclosure in accordance with applicable state and federal law, and in some cases, may no longer be protected by federal privacy law.

**Withdrawing your consent:** You may withdraw your consent at any time by contacting your VillageHealth care team. If VillageHealth has already used or accessed your health information up until the point you withdraw your consent, VillageHealth is not required to return or remove that health information from your records. Your consent withdrawal may also be limited by state law.

**Copy of consent forms:** You are entitled to receive a copy of this consent form and accompanying information after you sign it.

**Penalties for Improper Access to or Use of Your Information:** There are penalties for inappropriate access to, or use of, your health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, please contact us at 855-472-9822 or privacy@davita.com; or follow the complaint process of the U.S. Department of Health Human Services, Office for Civil Rights at the following link: http://www.hhs.gov/ocr/privacy/hipaa/complaints/

# NOTICE OF PRIVACY PRACTICES

**EFFECTIVE AS OF JAN. 01, 2023**

**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.**

**This notice covers the following entities: DaVita Inc. managed or operated dialysis facilities as well as DVA Laboratory Services Inc., Total Renal Laboratories, Inc., Nephrology Practice Solutions, LLC, Nephrology Medical Associates of Georgia, LLC, DNP Management Company, LLC., and VillageHealth DM, LLC (collectively referred to here as "VillageHealth*"). If you have questions or concerns, please contact your clinic or the Privacy Office using the contact information provided at the end of this document.**

## OUR PRIVACY COMMITMENT

VillageHealth is committed to respecting and protecting patient privacy, which includes explaining how we use and manage your health information, as well as what rights and choices you have related to that information. We hope this summary of your rights, including your choices and our responsibilities, helps you to understand how we follow the law and respect your privacy. We are providing you with this notice, as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). As a health care provider, HIPAA requires VillageHealth to respect and protect patient 'protected health information' (or, "PHI"), and requires us to be transparent with you regarding our practices concerning our collection, use and sharing of PHI obtained from or about you. HIPAA also requires us to make you aware of your privacy rights, including your ability to exercise your choice (i.e., "consent," also referred to as an "authorization") and provide your permission for us to collect, use, or share your PHI.

## YOUR RIGHTS

**When it comes to your health information, you have certain rights.** This section explains your privacy rights and our responsibilities to help you. Unless otherwise specified, you may exercise the rights listed below by contacting us.

**View your health information**

- You can ask to see the health information we have about you or request a copy of your medical record.
- If we are unable to fulfill your request, we will tell you why in writing.

**Ask us to correct your medical record**

- You can ask us to correct your health information about you that you think is incorrect or incomplete.
- We may reject your request, but we'll tell you why in writing.

**Request confidential communications**

- You can ask us to contact you in a specific way *(Ex: home or office phone)* or to send mail to a different address to enhance your privacy.
- We will work to accept all reasonable requests.

**Ask us to limit what we use or share**

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- There are some instances where we will not agree to your request. *Ex: We may deny your request if your request would negatively affect your care.*
- If you pay for a healthcare service out-of-pocket, you can ask us not to share the information pertaining to that service or item with your health insurer for the purpose of payment or our operations. We will work to accept this request unless an applicable law requires us to share that information.

**Get a list of those with whom we've shared information**

You can ask for a list (also referred to by HIPAA as an "accounting") of the times we've shared your health information, who we shared it with, and why. We can provide a list of these details over the six (6) years prior to your request. We will include all the disclosures except those made for treatment, payment, and health care operations, and certain other disclosures. We'll provide one (1) accounting in a calendar year for free but will charge a reasonable, cost-based fee if you ask for others within twelve (12) months.

**Get a copy of this privacy notice**

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

**Choose someone to act for you**

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

**File a complaint if you believe your rights are violated**

- If you believe we have violated your privacy rights described in this Notice of Privacy Practices, you can complain by contacting the DaVita Privacy Office at privacy@davita.com, or by calling **(855) 472-9822**, or writing to: **DaVita Privacy Office, 2000 16th St., Denver, CO 80202**.
- You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by calling 1-877-696-6775, or sending a letter to 200 Independence Ave. SW, Washington, DC 20201.
- We will not retaliate against you for filing a complaint or making us aware of any HIPAA complaints or grievances.

**Information We Collect**

We collect from or about you individually identifiable personal information, including PHI as defined by HIPAA that is collected at our clinics, and other personal information that we may obtain from you or other sources such as our DaVita.com website and third-party partners and service providers that you may have interacted with. We will combine the information we obtain from or about you from such sources. For additional information and examples of the types of individually identifiable personal information we collect, please review our DaVita.com Privacy Policy, available at: https://www.davita.com/privacy-policy.

## YOUR CHOICES

For certain health information, you can tell us your choices about what we use or share. If you prefer how we use or share your information in the situations described below, talk to us. Tell us what you want us to do, and we will work with you to understand your request and determine how we can follow your instructions.

**You have both the right and choice to permit or prohibit us from:**

- Using or sharing information with your family, close friends, or others involved in your care. *Ex: If you are not able to tell us your preference. Ex: you are unconscious, we may use or share your information if we believe it is in your best interest.*

**We require your written permission before we:**

- Use or share your information for marketing purposes, except in limited circumstances.
- Share your psychotherapy notes, except in very limited circumstances.

- **In the case of fundraising:**
  We may contact you for fundraising efforts, but you can tell us not to contact you again for fundraising reasons.

**In the case of highly confidential information:**

When required by state or federal law, we apply additional privacy protections for certain information about you such as: HIV testing, substance use, and mental health. Unless permitted or required by law, we will obtain your permission before collecting, using or sharing that information.

Health Information Exchanges (HIE): We may share and access your health information electronically with other health care organizations through a Health Information Exchange (HIE), for treatment, payment, and health care operations.

- If your state requires an affirmative opt-in consent to participate in the HIE, you will be provided with an opt-in form to review, sign, and return. In other states, you can simply choose not to have your health information shared through any of our HIE networks at any time (i.e. “opt-out”).
- To “opt-out” from your health information being shared and accessed in a HIE, you may contact your care team. Even if you decide to opt-out, there may still be instances where your health information is shared through the HIE as required by state law. Additionally, your health information can continue to be shared through other means, such as fax or mail, pursuant to state and federal law.
- If you previously opted-out and now want to opt back in, you may do so at any time by contacting your VillageHealth care team.

## OUR USES AND DISCLOSURES

**How do we typically use or share your health information? We typically use or share your health information in the following ways.**

**Treating you**

We can use your health information and share it with other health care professionals who are treating you. *Ex: treatment may include interdisciplinary conferences with team members from VillageHealth and support care teams from other facilities involved in your care and treatment or other providers who may be able to provide information or insight in the development and coordination of your plan of care.*

**Billing for your services**

We can use and share your health information to bill and receive payment from health plans or other entities. *Ex: We give information about you to your health insurance plan so it will pay for your services.*

**Running our organization (also known as Health Care Operations)**
We can use and share your health information to run our facilities, improve your care, and contact you when necessary. *Ex: We use your information in connection with other information we have to learn more about our patients so we can improve the treatment we provide.*

**How else can we use or share your health information?**
We are allowed, and sometimes required, to use or share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet certain conditions in the law before we can share your information for these purposes.

**Helping with public health and safety issues**
We can use and share health information about you for certain purposes such as:
- Preventing disease
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety
- Ensuring the safety of a workplace

**Conducting clinical research**
We can use or share your information for health research if you have authorized it or if an Institutional Review Board/Privacy Board has granted the researcher a Waiver of Authorization

**Complying with the law**
We will share information about you if required by state or federal laws, including when the Department of Health and Human Services wants to see that we are complying with federal privacy law.

**Responding to organ and tissue donation requests**
We can share health information about you with organ procurement organizations.
**Working with a coroner, medical examiner, or funeral director**
We can share health information with a coroner, medical examiner, or funeral director so they can carry out their duties.

**Addressing workers' compensation, law enforcement, and other government requests**, we can use or share health information about you:
- For workers' compensation claims to the extent authorized by state law
- For law enforcement purposes or to a law enforcement official if required;
- With health oversight agencies for activities authorized by law; or
- For special government functions such as prisons, military, national security, and protective services for the President of the United States.

**RESPOND TO LAWSUITS AND LEGAL ACTIONS:**
We can share health information about you in court or an administrative proceeding, or in response to a legal order, after certain requirements have been met.

**Our Responsibilities**
- We are required by law to maintain the privacy and security of your PHI.
- We will let you know if the privacy or security of your information was compromised.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us that we can in writing. You may change your mind at any time.

**Changes to the Terms of this Notice**
We can change the terms of this notice, and the changes may apply to all health information we have about you. The new notice will be available in our offices, on our website and upon your request.

**Contact Information**
Privacy Office: 2000 16th St., Denver, CO 80202, privacy@davita.com, (855) 472-9822.