
Last Name	First Name	M.I.
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VERMILLION PARKE COMMUNITY HEALTH CENTER

Acknowledgment of Receipt of Notice of Privacy Practice

By my signature below, I acknowledge that I have received the Notice of Privacy Practice.

Signature

Date

Relationship to patient (if not signed by patient)

Staff initials

NOTICE OF PRIVACY PRACTICES

Effective Date of this Notice: April 14, 2003
Revised Date of this Notice: September 23, 2013

Vermillion Parke Community Health Center
777 S. Main Street, Suite 100
Clinton, IN 47842

201 W. Academy St.
Bloomington, IN 47832

114 N. Division St.
Cayuga, IN 47928

Mobile School-Based Health Center

Our Pledge Regarding Medical Information

We understand that medical information about you and your health is personal, and we are committed to protecting your privacy. We create a record of the care and services you receive at this facility. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all records of your care generated by this facility whether in paper or electronic form.

How We May Use and Disclose Your Medical Information

The following categories describe different ways that we use and disclose medical information. Information may be disclosed in writing, orally or electronically. Not every use or disclosure in each category will be listed; however, all of the ways we are permitted to use and disclose information will fall within one of the categories.

1. For Treatment:

We will use your medical information to provide you with quality treatment or services. Your information may be accessed by various people who are involved in your care (example: doctors, nurses, technicians, students, clerks, laboratory personnel, etc...). Different departments may share medical information about you in order to coordinate the different things you need. For example: a doctor will share your medical information with another physician if you are referred for specialized care. We may also share your medical information with a family member or friend who will assist with your care outside this facility.

2. For Payment:

We will use and disclose your medical information so that we can bill for the services you received and collect payment. For example, we may share information with your insurance company to obtain prior approval for treatment when applicable, or to bill and receive reimbursement for treatment you received.

3. For Operations:

We may use and disclose your medical information as necessary to run our facility and provide our patients with quality care. Examples of uses and disclosures include, but are not limited to, the following:

- To send you appointment reminders;
- To inform you about or recommend possible treatment options or alternatives that may be of interest to you;
- To provide you with information about health-related benefits and services that may be of interest to you;
- To review our services, evaluate our performance, and decide what additional services we should offer;
- To volunteers who assist our patients;
- For research purposes under certain circumstances;

- To outside organizations called our Business Associates who perform a task on our behalf, such as an outside billing agency;
 - For fundraising efforts, but you have the right to opt out of such communications;
 - To doctors, nurses, students and other personnel for review and learning purposes.
4. As required by Law:
- We may use and disclose our medical information as required in the following situations:
 - To prevent a serious threat to your health and safety or the health and safety of another person or the public;
 - To report public health activities or risks, such as infectious disease or abuse cases;
 - To report births or deaths;
 - For health oversight activities, which could include audits, investigations, inspections and licensure;
 - To a court or in response to an administrative order, subpoena, discovery request or other process if you are involved in a lawsuit or dispute;
 - To law enforcement officials in response to a criminal investigation, warrant, ect.;
 - To federal officials for intelligence and other national security activities authorized by law;
 - To coroners, medical examiners or funeral directors;
 - To worker compensation programs when applicable;
 - To organ donation or procurement programs when applicable;
 - To provide legally required notices of unauthorized access to or disclosure of your health information; and
 - To military command authorities, as applicable, if you are a member of the Armed Forces.
5. Your Written Authorization is Required for Other Uses and Disclosures:
The following uses and disclosures of your medical information will be made only with your written authorization:
- Uses and disclosures of psychotherapy notes;
 - Uses and disclosures of your medical information for marketing purposes; and
 - Disclosures that constitute a sale of your medical information.
6. Other Uses of Medical Information:
Other uses and disclosures of medical information not covered by this Notice or law will be made only with your written permission. If you provide us permission to use or disclose your medical information, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures we may have already made while we had your permission, and that we are required by law to retain our records of the care we provided to you.

Your Rights Regarding Your Medical Information

1. Right to Inspect and Copy:
As a patient of ours, you have the opportunity to review your information or receive copies of your records. This includes medical and billing records, but does not include psychotherapy notes. If you request a copy of your records, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request. To review or request a copy of your record, contact the medical records department at (765) 828-1003 for the Vermillion-Parke Community Health Center.
2. Right to Amend:
If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, contact Elizabeth Burrows, CEO, at (765) 828-1003. They will give you the appropriate form to complete which must include the reason for your request. We will deny your request for an amendment if it is not in writing or does not include a reason for the request. In addition, we may deny your request if it is deemed that our information is accurate and complete.
3. Right to Accounting of Disclosures:
You have the right to request an accounting of disclosures, that is, a list of the persons to whom we sent some or all of your medical information. This accounting can begin no earlier than our HIPAA Privacy Standards compliance effective date of April 14, 2003, and can include a maximum of six-year period. Contact Elizabeth Burrows, CEO at (765) 828-1003 to begin this process. We will charge you for the cost

of providing more than one accounting during a 12-month period. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any charges are incurred.

4. Right to Get Notice of a Breach:

You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

5. Right to Request Restrictions:

You have the right to request a restriction or limitation of the medical information we use or disclose about you for treatment, payment or other health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in our care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about this visit. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, contact Elizabeth Burrows, CEO at (765) 828-1003. You will be given the appropriate form to complete your request which must include:

- What information you want to limit;
- Whether you want to limit our use, disclosure, or both; and
- To whom you want the limits to apply, for example, disclosures to your spouse

You have the right to restrict certain disclosures of PHI to your health plan when you agree to pay out-of-pocket in full for the healthcare item or services.

6. Right to Request Confidential Communications:

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. You may request confidential communication during your registration process. Any request made after you have been registered, should be made to Elizabeth Burrows, CEO at (765) 828-1003.

7. For More Information or to Report a Problem

If you have questions or would like additional information about our privacy practices or this Notice, you may contact our Compliance Department during normal business hours at 765-828-1003. If you believe your privacy rights have been violated, you can file a complaint with the Compliance Department, at:

VPCHC
777 S. Main St., Suite 100
Clinton, IN 47842
765-828-1003

Or with the Office of Civil Rights at:

233 N. Michigan Ave, Suite 240
Chicago, IL 60601
Fax: (312) 866-1807

You will not be penalized for filing a complaint.