Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Northern Oswego County Ambulance, Inc. is required by law to provide you with this Notice so that you will understand how we may use or share your information from your Designated Record Set. The Designated Record Set includes financial and health information referred to in this Notice as "Protected Health Information" ("PHI") or simply "health information". We are required to adhere to the terms of the version of this Notice currently in effect.

I. **Uses and Disclosures of PHI for Treatment, Payment and Health Care Operations:** NOCA may use your PHI for the purposes of treatment, payment, and health care operations. In most cases, we will obtain your permission to disclose information for these purposes. However, we are permitted by law to provide a copy of your pre-hospital care report to a hospital to which we transport you and to an agent of the New York State Department of Health for use in the State's quality assurance program without first obtaining you consent. Other examples of our uses and disclosures of your PHI are:

A. **For treatment.** This includes such things as obtaining verbal and written information about your medical condition and treatment from you as well as from others, such as doctors and nurses who give orders to allow us to provide treatment to you. We may give your PHI to other health care providers involved in your treatment, and may transfer your PHI via radio or telephone to the hospital or dispatch center.

B. **Treatment Alternatives.** We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

C. **For Payment.** We may use and disclose health information about you so that the treatment and services you receive may be billed to you, your insurance company, or third party. For an example, in order to be paid, we may need to share information with your health plan about services provided to you. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. This also includes collecting outstanding accounts.

D. **For Health Care Operation.** This includes quality assurance activities, licensing, and training programs to ensure that our personnel meet our standards of care and follow established policies and procedures, as well as certain other management functions. This is necessary to ensure that all patients receive quality care.

E. **Health Related Benefits and Services.** We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

F. **Reminders for Scheduled Transports and Information on Other Services.** We may also contact you to provide you with a reminder of any scheduled appointments for non-emergency ambulance and medical transportation, or to provide information about other services we provide.

E. **Fundraising.** We may contact you when we are in the process of raising funds for NOCA, or to provide you with information about our annual subscription or membership program.

F. **For All Other Uses and Disclosures.** All other uses and disclosures of information not contained in this NPP will not be disclosed without your authorization.

G. **For Military and Veterans.** If you are a member of the armed forces, we may disclose health information about you as required by military authorities. We may also disclose health information about foreign military personnel to the appropriate foreign military authority.

H. **Workers' Compensation.** We may disclose health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

I. **For Public Health Risks.** We may disclose health information about you for public health purposes, including prevention or control of disease, injury, or disability, reporting births and deaths; reporting reactions to medications or problems with products, and notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease.

J. **Protective Services for the President and Others.** We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

II. **Uses and Disclosures of PHI without Your Authorization:** NOCA is permitted to use and disclose your PHI without your written authorization, or opportunity to object to the use or disclosure in certain situations, including:

- To a public health authority in certain situations as required by law (such as to report abuse, neglect or domestic violence);
- For health oversight activities including audits or government investigations, inspections, disciplinary proceedings, and other administrative or judicial actions undertaken by the government (or their contractors) when required by law to oversee the health care system (These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.);
- For law enforcement activities in limited situations, such as when responding to a warrant, identifying or locating a suspect, fugitive, material witness, or a missing person, and about a victim of a crime, under limited circumstances, we are unable to obtain the person's agreement;
- For military, national defense, security, and veterans and other special government functions;
- To avert a serious threat to the health and safety of a person or the public at large;
- For workers' compensation purposes in compliance with workers' compensation laws.
- To coroners, medical examiners, and funeral directors for identifying a deceased person, determining cause of death, or carrying on their duties as authorized by law;
- If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ donation and transplantation;
- For research projects, but this will be subject to strict oversight and approvals;

We may also use or disclose health information about you in a way that does not personally identify you or reveal who you are.

You may revoke your authorization at any time, in writing, except to the extent that we have already used or disclosed medical information in reliance on the authorization.

III. **Uses and Disclosures of Your PHI that May be Made with Your Consent, Authorization, or Opportunity to Object:** In some circumstances, you have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not able to agree or object

to the use or disclosure of the protected health information, then your health care provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Individuals Involved in Your Health Care; Unless you object, we may disclose to a member of your family, a relative, a close friend, or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. We may also give information to someone who helps pay for your care. We may also use or disclose protected health information to notify or assist in notifying a family member, personal representative, or any other person who is responsible for your care, of your location, general condition, or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and coordinate uses and disclosures to family or other individuals involved in your care.

IV. Patient Rights: As a patient, you have a number of rights with respect to your PHI that we maintain, including:

Access: The right to access, copy, or inspect your PHI. This means you may inspect and copy most of the medical information about you that we maintain, including billing records, with limited expectations.

If you would like to inspect or obtain copies of your health information, you must make a request in writing to the Privacy Officer listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you 75 cents for each page. If we deny you access, we will provide you with written reason for the denial and explain any right you have to a review of the denial.

Accounting of Disclosures: You have the right to receive an accounting of disclosures we have made, if any, of your protected health information after April 14, 2003. The accounting time period is no longer than 6 years after the disclosure. This applies to disclosures made pursuant to your authorization. We will provide you with the date on which we made the disclosure, the name of the person or entity to which we disclosed your protected health information and the reason for the disclosure. If you request this accounting of disclosures more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact the Privacy officer listed at the end of this Notice for a full explanation of our fee structure.

Restriction Requests: You have the right to request restrictions on our uses or disclosures of your protected health information. We are not required to agree to these additional restrictions if we believe it is in your best interest to permit uses and disclosures of your protected health information will not be restricted. If we do agree to the requested restriction, we must abide by the agreed to restriction except in an emergency. Your request for any restrictions must be in writing, sent to the attention of the Privacy Officers at the address listed at the end of this Notice. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your restriction must contain an expiration date. Contact the Privacy Officer listed at the end of this Notice for additional information. We will not ask you the reason for your request. If you do not tell us how or where you wish to be contacted, we do not have to follow your request.

Confidential Communication: You have the right to request that we communicate with you in confidence about your protected Health information by alternative means or to an alternative location. We will accommodate reasonable requests. We may condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact that continues to permit us to bill and collect payment from you. You must make this request in writing to our Privacy Officer listed at the end of this Notice.

Amendment: You have the right to request that we amend your protected health information. You may ask us to include additional information in your medical records. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended, or in certain other cases. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. We reserve the right to prepare a rebuttal to your statement of disagreement and will provide you with a copy of any such rebuttal. If we accept your request to amend the information, we will make reasonable efforts to inform our business associates of the amendment and to include the changes in any future disclosures of that information.

Internet, Electronic Mail, and the Right to Obtain Copy of Paper Notice on Request: If we maintain a web site, we will prominently post a copy of this Notice on our web site. If you allow us, we will forward you this Notice by electronic mail instead of on paper and you may always request a paper copy of the Notice.

Revisions to the Notice: NOCA reserves the right to change the terms of this Notice at any time, and the changes will be effective immediately and will apply to all protected health information that we maintain. Any material changes to the Notice will be promptly posted in our facility and posted to our web site, if we maintain one. You can get a copy of the latest version of this Notice by contacting our Privacy Officer.

V. Your Legal Rights and Complaints: You also have the right to complain to us, or to the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against in any way for filing a direct complaint with us or with the government. Should you have any questions, comments or complaints about our privacy practices, you may direct all inquires to our Privacy Officer listed at the end of this Notice.

Privacy Officer Contact Information:

Privacy Officer
Northern Oswego County Ambulance, Inc.
21 Delano Street
Pulaski, NY 13142

315-298-6220 Fax 315-298-2258

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

I. **Acknowledgement of Practice's *Notice of Privacy Practices*:**

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices(NPP) and agree to its terms.

______________________ ______________ ______________________________

Name of Patient **Date of Birth** **Signature of Patient/Parent/Guardian** **Date**

II. **Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:**

I agree that the practice may disclose certain of my health information to a Personal Representative of my choosing, since such person is involved with my health care or payment relating to my health care. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

Print Name:______________________________ **Last four digits of his/her SSN (required):**__________

Print Name:______________________________ **Last four digits of his/her SSN (required):**__________

Print Name:______________________________ **Last four digits of his/her SSN (required):**__________

III. **Request to Receive Confidential Communications by Alternative Means:**

As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communications to me by the alternative means that I have listed below.

Home Telephone Number:

____

____ OK to leave message with detailed information

____ Leave message with call back numbers only

Work Telephone Number:

____

____ OK to leave message with detailed information

____ Leave message with call back numbers only

Written Communication Address:

____

____ OK to mail to address listed above

____ E-mail me at:____________________

Fax Communication:

____

____ OK to Fax at the number listed above

____ E-mail me at:____________________

Other:____

______________________________ ______________________________

Name of Patient (Print) Signature Date

Witness: ______________________ Date: ______________