Michigan Department of Health & Human Services

PRIVACY NOTICE

For Hospital Name

Effective May 7, 2019

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

PLEASE REVIEW IT CAREFULLY.

Understanding the Type of Information We Have. When you're evaluated by or admitted to **Hospital Name**, a record of your stay is made. This record is often called your health or medical record. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This is used for many purposes. Most importantly, your records help us plan, coordinate, and document your care and treatment.

Our Privacy Commitment To You. We care about your privacy. The information we collect about you is private. We are required to give you a notice of our privacy practices, to follow these practices, and to notify affected individuals following a breach of unsecured protected health information. Only people who have both the need and the legal right may see your information. We may disclose your information without your permission for purposes of treatment, payment, health care operations or when we are required by law to do so.

Examples of Disclosures for Treatment, Payment, and Health Care Operations

We will use your health information for treatment.

For example: Information obtained by a nurse, psychiatrist, physician, or other member of your treatment team will be recorded in your record and used to determine the course of your treatment that should work best for you. Your psychiatrist/physician will document in your record his or her expectations of the members of your treatment team. Members of your treatment team will then record the actions they took and their observations. In that way, the psychiatrist/physician will know how you are responding to treatment.

We may also provide your psychiatrist/physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you're discharged from this hospital (if applicable).

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health care operations.

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case or others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and services we provide.

- **Individuals Involved In Your Care***:* With your consent, we may notify or release information about you to a friend or family member who is involved in your care.
- **Treatment.** We may disclose health information about you to coordinate your health care. For example, we may notify your doctor about the results of tests performed by our laboratory.
- **Payment.** We may use and disclose information so the testing you have done can be properly billed and paid for. For example, we may submit your name, date of birth, gender, tests performed, and other

information to bill for laboratory services.

- **Health Care Operations.** We may need to use and disclose information to operate the program. For example, we may use information to review the quality of the laboratory's operations.
- **Exceptions.** For certain kinds of records, such as psychotherapy notes, your permission may be needed even for release for treatment, payment and health care operations.
- **As Required By Law.** We will release information when we are required by law to do so. Examples of such releases would be for law enforcement or national security purposes, subpoenas or other court orders, communicable disease reporting, disaster relief, review of our activities by government agencies, to avert a serious threat to health or safety or in other kinds of emergencies.
- **With Your Permission.** If you give us permission in writing, we may use and disclose your health information. If you give us permission, you have the right to change your mind and revoke it. This must be in writing, too. We cannot take back any uses or disclosures already made with your permission.

ADDITIONAL EXAMPLES OF DISCLOSURES THAT MAY BE MADE WITHOUT YOUR PERMISSION

- ***BUSINESS ASSOCIATES:*** There are some services provided in our organization through contracts with Business Associates. Examples include contractors that provide laboratory billing services or specimen transport. When these services are contracted, we may disclose your health information to our Business Associates so that they can perform the job we've asked them to do. To protect your health information, however, we require the Business Associate to appropriately safeguard your information.
- ***RESEARCH:*** Information will not be provided to researchers without your signed informed consent, unless the research has been approved by an institutional review board or a privacy board and the researchers ensure the privacy of your information.
- ***FOOD AND DRUG ADMINISTRATION (FDA):*** We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.
- ***WORKER COMPENSATION:*** We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.
- ***PUBLIC HEALTH:*** As authorized by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.
- ***LAW ENFORCEMENT:*** We may disclose health information for law enforcement purposes as required by law or in response to a valid court order.
- ***VICTIMS OF ABUSE, NEGLECT, OR DOMESTIC VIOLENCE:*** We may disclose information about you to a government authority, such as a social service or protective agency, if we reasonably believe you are a victim of abuse, neglect, or domestic violence. We will only disclose this type of information to the extent required by law, if you agree to the disclosure, or if the disclosure is allowed by law and we believe it is necessary to prevent serious harm to you or someone else.
- ***TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY:*** If there is a compelling need, we may disclose information to prevent a serious threat to your health or safety or the health and safety of the public or another person.
- ***HEALTH OVERSIGHT***: We may disclose health information to a health oversight agency for activities authorized by law. The oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- ***INMATES:*** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary for the institution to provide you with health care; to protect your health and safety or the health and safety of others; or for the safety and security of the correctional institution.

- ***Special Situations:*** Consistent with applicable law, we may disclose health information to funeral directors, coroners, medical examiners; as required by military command authorities; and for national security activities.
- ***Psychotherapy Notes:*** We will not disclose psychotherapy notes without an authorization from you except: (1) to carry out treatment, payment, or health care operations; (2) when required to investigate or determine our compliance with the law; (3) when the law requires us to disclose them; (4) to a health oversight agency to oversee the originator of the notes; (5) to a coroner or medical examiner to identify a deceased person; or (6) when necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

If we use or disclose your information for any purpose that is not described in this notice, we will do so only with your permission. For example, we will not sell, market, or use your information for fundraising without your permission.

Your Privacy Rights

You have the following rights regarding the health information that we have about you. Your requests must be made in writing to the Director of Medical Records/Designee of **State Hospital Name**, as described below.

- **Your Right to Inspect and Copy.** In most cases, you have the right to look at or get copies of your records. You may be charged a fee for the cost of copying your records.
- **Your Right to Amend.** You may ask us to change your records if you feel that there is a mistake. We can deny your request for certain reasons, but we must give you a written reason for our denial.
- **Your Right to a List of Disclosures.** You have the right to ask for a list of disclosures made in the six years before the date of your request. This list will not include the times that information was disclosed for treatment, payment, or health care operations. The list will not include information provided directly to you or your family, or information that was sent with your permission.
- **Your Right to Request Restrictions on Our Use or Disclosure of Information.** You have the right to ask for limits on how your health information is used or disclosed. We are not required to agree to such requests unless (1) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law and (2) the protected health information pertains solely to a health care item or service for which you, or a person other than a health plan on your behalf, has paid us in full. We will notify you if we are unable to agree to a requested restriction.
- **Your Right to Request Confidential Communications.** You have the right to ask that we share information with you in a certain way or in a certain place. For example, you may ask us to send information to your work address instead of your home address. We may deny your request unless you clearly state your safety is at risk.
- **Your Right to Revoke Authorization**. If you give us permission to use or disclose your health information, you have the right to change your mind and revoke it. This must be in writing. We cannot take back any uses or disclosures already made with your permission.
- **Additional Rights**: Michigan's Mental Health Code also provides you with rights concerning the use and disclosure of your health information, as well as other rights. Please refer to your "Your Rights" booklet for information on your rights under the Michigan Mental Health Code.

Changes to this Notice

We reserve the right to revise this notice. A revised notice will be effective for health information we already have about you as well as any information we may receive in the future. We are required by law to comply with whatever notice is currently in effect. We will provide you a copy of the revised notice or send you an electronic copy. We will provide a copy to each recipient when he/she is admitted.

For More Information

If you have questions or would like additional information, you may contact the Privacy Officer or his/her designee at the phone number listed below, or by writing:

Privacy Officer
Address
Phone number

How to Use Your Rights Under this Notice

If you want to use your rights under this notice, you may call us or write to us. If your request must be in writing, we will help you prepare your written request, if you wish. For assistance, contact the Privacy Officer or his/her designee at the phone number or address listed above.

COMPLAINTS

If you believe your privacy rights have been violated, you can file a complaint with the federal government and the MDHHS Office of Recipient Rights (ORR). You will not be penalized for filing a complaint with either the federal government or the MDHHS Office of Recipient Rights (ORR):

Hospital's ORR contact information	**OR**	Phone: MDHHS ORR Hotline: 800-854-9090 Michigan Relay Center: 711

You also have the right to file a complaint with the federal government. Written complaints should be sent to:

Centralized Case Management Operations U.S. Department of Health and Human Services 200 Independence Avenue, S.W. Room 509F, HHH Bldg Washington, D.C. 20201	**OR**	Phone: 800-368-1019 TDD: 800-537-7697 Email: OCRComplaint@hhs.gov

You will not be penalized or retaliated against for filing a complaint with either MDHHS or the federal government.

Copies of this Notice

You have the right to receive an additional copy of this notice at any time. Please call or write to us to request a copy.

This notice is available in other languages and alternate formats that meet the guidelines for the Americans with Disabilities Act (ADA).	Esta notificació está disponible en otras lenguas y formatos diferentes que satisfacen las normas del Act a de Americans with Disabilities (ADA).	يتوفر هذا البيان في لغات وصيغ أخرى تفي بإرشادات وضوابط قانون ذوي الإعاقات الأمريكيين (ADA).

Non-Discrimination Statement

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.

Michigan Department of Health and Human Services

PRIVACY NOTICE
STATEMENT OF RECEIPT

My signature below indicates that I have received a copy of the Hospital's Notice of Privacy Practice as required by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

____________________________________ ____________________
Patient's or Responsible Party's Signature Date

____
Relationship to Patient (if applicable)

____________________________________ ____________________
Witness Signature Date