**NOTICE OF PRIVACY PRACTICES**

Procedure: The Notice of Privacy Practices describes how Protected Health Information may

be used and disclosed. The Notice may be amended from time to time and, if amended, shall describe any amendments that apply retroactively to Protected Health Information maintained prior to the date of the amendment. Protected Health Information will not be used or disclosed in any manner that contravenes the Notice of Privacy Practices then in effect. The Notice of Privacy Practices that is currently in effect shall be posted in the waiting room or other prominent location and shall be available for distribution to patients who request it, and shall be posted on the Punxsutawney Area Hospital’s website.

The Privacy Officer / Contact Person or his/her designees shall be responsible for maintaining, evaluating and recommending amendments to the Notice of Privacy Practices. At all times, the Privacy Officer shall follow the directives of the HIPAA Privacy Regulations and any clarifications or guidance issued by the Department of Health and Human Services. The Chief Executive Officer shall have ultimate authority to approve or disapprove any Notice or proposed

amendment.

**Written Acknowledgment:** Except in emergencies, when a patient signs in for his or her first visit, the registration personnel shall provide the patient with a Notice of Privacy Practices and Written Acknowledgment of Receipt of Notice of Privacy Practices form. The patient shall be asked to return the Written Acknowledgment form.

**Patient Refusal to Sign Acknowledgment:** If the patient indicates a desire not to sign the Acknowledgment form, the staff member shall inquire about the reasons for the patient’s refusal and shall inform the patient that signing the Acknowledgment form simply indicates that the patient has received the Notice. If the patient still refuses to sign, the registration clerk shall complete the attached form containing the information below:

a. that the patient was provided with a Notice and Written Acknowledgment form, but refused to sign;

b. the name of the staff member who provided the Notice and form;

c. whether the staff member informed the patient that signing the form merely indicates the patient’s acknowledgment that he or she received the Notice;

d. that the patient nonetheless refused to sign; and

e. the date and time (approximately) of the conversation.

**Emergency Situations:** Patients whose first service occurs under emergency circumstances need not be provided a notice:

a. The patient’s medical record shall be marked to indicate that no Notice was provided due to the emergency condition. After the emergency condition has been stabilized, the Notice shall be provided and the medical record shall be marked accordingly. No written

acknowledgment must be obtained.

b. If the patient is transferred to another unit, floor or department prior to stabilization of the emergency condition, a Notice shall be placed in the Medical Record, to be provided to the patient by a staff member of the receiving department upon the patient’s stabilization. No written acknowledgment must be obtained.

c. If the patient is transferred to another facility prior to stabilization of the emergency condition, a registration clerk on duty at the time of the patient’s transfer shall cause a Notice to be mailed to the patient’s last known address with a note indicating that the Notice being provided is the Notice that was in effect on the date the patient received treatment. No written acknowledgment must be obtained.

**Documentation:** The patient’s written acknowledgment of receipt of the Notice of Privacy Practices, or the documentation explaining why written acknowledgment was not obtained, shall be maintained in the patient’s record for a minimum of six years.

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE**

**USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS**

**INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This notice describes how Punxsutawney Area Hospital will use and disclose your health

information. The policies outlines in this Notice apply to all of your health information generated

by Punxsutawney Area Hospital, whether recorded in your medical record, invoices, payment

forms, videotapes or other ways. Similarly, these policies apply to the health information gathered from other Organizations by any health care professional, employee or volunteer who participates in your care.

**USES AND DISCLOSURES OF YOUR HEALTH INFORMATION**

1. In some circumstances we are permitted or required to use or disclose your health information without obtaining your prior authorization and without offering you the opportunity to object. These circumstances include:

a. Uses or discloses for purposes relating to treatment, payment and health care operations.

i. Treatment. We may use or disclose your health information for the

purpose of providing, or allowing others to provide, treatment to you. An

example would be if your primary care physician discloses your health

information to another doctor for the purposes of a consultation. Also, we

may contact you with appointment reminders or information about

treatment alternatives or other health-related benefits and services that may

be of interest to you.

ii. Payment. We may use and/or disclose your health information for the

Purpose of allowing us, as well as other entities, to secure payment for the

health care services provided to you. For example, we may inform your

health insurance company of your diagnosis and treatment in order to assist

the insurer in processing our claim for health care services provided to you.

iii. Health Care Operations. We may use and/or disclose your information for

the purposes of our day-to-day functions, but only to the extent that we both have a relationship with you. For example, we may compile your health information, along with that of other patients, in order to allow a team of our health care professionals to review that information and make

suggestions concerning how to improve the quality of care provided at Punxsutawney Area Hospital. Also, we may contact you as part of our

efforts to raise funds for the Organization. All fundraising communications will include information about how you may opt out of future fundraising communications.

b. To create material(s) that originally had any identifying information concerning you deleted from the final material(s);

c. When required by law;

d. For public health purposes;

e. To disclose information about victims of abuse, neglect, or domestic violence;

f. For health oversight activities, such as audits or civil, administrative or criminal investigations;

g. For judicial or administrative proceedings;

h. For law enforcement purposes;

i. To assist coroners, medical examiners or funeral directors with their official duties;

j. To facilitate organ, eye or tissue donation;

k. For certain research projects that have been evaluated and approved through a research approval process that takes into account patients’ need for privacy;

l. To avert a serious threat to health or safety;

m. For specialized governmental functions, such as military, national security, criminal corrections, or public benefit purposes; and

n. For workers’ compensation purposes, as permitted by law.

2. We may also use or disclose your health information in the following circumstances.

However, except in emergency situations, we will inform you of our intended action

prior to making any such uses and disclosures and will, at that time, offer you the

opportunity to object.

a. Directories. We may maintain a directory of patients that includes your name

and location within the facility, your religious designation, and information about your condition in general terms that will not communicate specific medical information about you. Except for your religion, we may disclose this information to any person who asks for you by name. We may disclose all directory information to members of the clergy.

b. Notifications. We may disclose to your relatives or close personal friends any health information that is directly related to that person’s involvement in the provision of, or payment for, your care. We may also use and disclose your health information for the purpose of locating and notifying your relatives or close personal friends of your location and general condition or death, and to Organizations that are involved in those tasks during disaster situations. Except as described above, disclosures of your health information will be made only with your written authorization. You may revoke your authorization at any time, in writing, unless we have taken action in reliance upon your prior authorization, or if you signed the authorization as a condition of obtaining insurance coverage.

**YOUR RIGHTS**

1. To Request Restrictions. You have the right to request restrictions on the use and disclosure of your health information for treatment, payment or health care operations purposes or notification purposes. We are not required to agree to your request. If we do agree to a restriction, we will abide by that restriction unless you are in need of emergency treatment and the restricted information is needed to provide that emergency treatment. To request a restriction, submit a written request to the Contact listed on the final page of this Notice.

2. To Limit Communications. You have the right to receive confidential communications about your own health information by alternative means or at alternative locations. This means that you may, for example, designate that we contact you only via e-mail, or at work rather than home. To request communications via alternative means or at alternative locations, you must submit a written request to the Contact listed on the final page of this Notice. All reasonable requests will be granted.

3. To Access and Copy Health Information. You have the right to inspect and copy any health information about you other than psychotherapy notes, information compiled in anticipation of or for use in civil, criminal or administrative proceedings, or certain information that is governed by the Clinical Laboratory Improvement Act. To arrange for access to your records, or to receive a copy of your records, you should submit a written request to the Contact listed on the last page of this Notice. If you request copies, you will charged our regular fee for copying and mailing requested information. Despite your general right to access your Protected Health Information, access may be denied in some limited circumstances. For example, access may be denied if you are an inmate at a correctional institution or if you are a participant in a research program that is still in progress. Access may be denied if the federal Privacy Act applies. Access to information that was obtained from someone other than a health care provider under a promise of confidentiality can be denied if allowing you access would reasonably be likely to reveal the source of the information. The decision to deny access under these circumstances is final and not subject to review. In addition, access may be denied if (i) access to the information in question is

reasonably likely to endanger the life and physical safety of you or anyone else, (ii) the information makes reference to another person and your access would reasonably be likely to cause harm to that person, or (iii) you are the personal representative of another individual and a licensed health care professional determines that your access to the information would cause substantial harm to the patient or another individual. If access is denied for these reasons, you have the right to have the decision reviewed by a health care professional who did not participate in the original decision. If access is ultimately denied, the reasons for that denial will be provided to you in writing.

4. To Request Amendment. You may request that your health information be amended. Your request may be denied if the information in question: was not created by us (unless you show that the original source of information is no longer available to seek amendment from), is not part of our records, is not the type of information that would be available to you for inspection or copying (for example, psychotherapy notes), or is accurate and complete. If your request to amend your health information is denied, you may submit a written statement disagreeing with the denial, which we will keep on file and distribute with all future disclosures of the information for which it relates. Requests to amend health information must be submitted in writing to the Contact listed on the final page of this Notice.

5. To an Accounting of Disclosures. You have the right to an accounting of any disclosures of your health information made during the six-year period preceding the date of your request. However, the following disclosures will not be accounted for: (i) disclosures made for the purpose of carrying out treatment, payment or health care operations, (ii) disclosures made to you, (iii) disclosure of information maintained in our patient directory, or disclosures made to persons involved in your care, or for the purpose of notifying your family or friends about your whereabouts, (iv) disclosures for national security or intelligence purposes, (v) disclosures to correctional institutions for law enforcement officials who had you in custody at the time of

disclosure, (vi) disclosures that occurred prior to April 14, 2003, (vii) disclosures made pursuant to an authorization signed by you, (viii) disclosures that are part of a limited data set, (ix) disclosures that are incidental to another permissible use or disclosure, or (x) disclosures made to a health oversight agency or law enforcement official, but only if the agency or official asks us not to account to you for such disclosures and only for the limited period of time covered by that request. The accounting will include the date of each disclosure, the name of the entity or person

who received the information and that person’s address (if known), and a brief description of the information disclosed and the purpose of the disclosure. To request an accounting of disclosures, submit a written request to the Contact listed on the final page of this Notice.

6. To Obtain a Paper Copy of this Notice. You have the right to obtain a paper copy of

this Notice upon request.

**OUR DUTIES**

1. We are required by law to maintain the privacy of your health information and to provide you with this Notice of our legal duties and privacy practices.

2. We are required to abide by the terms of this Notice. We reserve the right to change

the terms of this Notice and to make those changes applicable to all health information

that we maintain. Any changes to this Notice will be posted at our facility, and will be

available from us upon request.

**COMPLAINTS**

You can complain to us and to the Secretary of the federal Department of Health and Human

Services if you believe your privacy right has been violated. To lodge a complaint with us, please

file a written complaint with the Contact set forth below. This Contact will also provide you with

information about our privacy policies upon request. No action will be taken against you for

filing a complaint.

**DESIGNATED CONTACT:**

**Privacy Officer**

**814-938-1851**

**Punxsutawney Area Hospital**

**81 Hillcrest Drive**

**Punxsutawney, PA 15767**