**PIONEERS MEDICAL CENTER**
**NOTICE OF PRIVACY PRACTICES CONSENT**

**(Note: All references to Pioneers Medical Center shall encompass Pioneers Hospital, Walbridge Memorial Convalescent Wing, aka Walbridge Wing, Meeker Family Health Center and Pioneers Medical Center Home Health)**

1. Uses and disclosures of your personal health information that does not require an authorization signed by you.

   a. **Treatment**
   We may use or disclose your personal health information to health care providers and their support staff so that we can properly manage your care and make the best decisions for treatment options. Your personal health information may be shared with other healthcare facilities in which case we transfer your care, refer your care to other healthcare providers or to other requesting healthcare organizations that are currently providing you with treatment.

   b. **Payment and Billing Activities**
   We may use your personal health information as it relates to payment for your healthcare treatment, such as sharing your information with our business office, our clearinghouse, any contracted workforce member and your insurance carrier responsible for payment of your bill. At times it may be necessary to send copies of your medical record to your insurance carrier in order to expedite payment.

   c. **Other Healthcare Operations**
   We may use or disclose your personal health information for quality assurance purposes, utilization review, support service operations, and other operational activities that necessitate the use of disclosure of your personal health information. Pioneers Medical Center restricts the amount of information used for these activities by allowing the minimum necessary to be used or disclosed in order to carry out the operational task.

2. Uses and Disclosures That Require Your Authorization

   Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke an authorization at any time as described below, under "Your Rights".

3. Other Uses and Disclosures

   a. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
   b. We may use or disclose your information as required by state and federal law.
   c. We may disclose your information for public health activities such as investigations related to death, child abuse, neglect, domestic violence, problems with products, reactions to medications, product recalls, disease infection exposure, and disease injury disability control prevention.
   d. We may disclose identification data for health oversight activities such as audits, investigations, and inspections by state and federal organizations.
   e. We may use or disclose your information pursuant to judicial and administrative proceedings.

f. We may disclose identification data as appropriate to law enforcement requests, for example to identify or locate a suspect, fugitive, material witness, or missing person.
g. We may disclose your personal health information when deceased to coroners, medical examiners, and funeral directors.
h. Specific to organ and tissue donation.
I. For research, provided authorization is IRB-approved or privacy board-approved.
j. During emergencies or to avert serious threat to health or safety.
k. For specialized government functions (military, inmates).
l. For worker's compensation.

4. You have the right to agree or object to the following uses and disclosures: (Please initial next to those uses and disclosures you object to. If you agree leave blank.)

- **Facility Directory:** Unless you object, we will use the following information in our facility directory: your name, location in which you are receiving care, your condition in general terms and your religious affiliation. We will disclose this information to anyone who asks for you by your complete legal name with the exception of your religious affiliation. Only clergy members will receive your religious affiliation.

If you object to this initial here: _____

- **Other involved in your healthcare:** Unless you object, we may disclose your personal health information to your family, significant other, relative or close friend for notification purposes, disaster relief efforts, or as it relates to their direct involvement of your treatment.

If you object to this initial here: _____

- **Fundraising activities:** We may also contact you to help us in our fundraising activities.

If you object to this initial here: _____

5. Your Rights

a. You have a right to access or obtain copies of your medical record. You may submit a written request to our Health Information Management Department and pay the copy fees and receive a copy of your medical record. We must respond to you within 30 days if the record is available at the time of the request and may respond to you within 60 days if not readily available.
b. You have a right to request confidential communications. All communications in our organization are confidential; however, you may request confidential communications by directing your request to the Health Information Management Department.
c. You have a right to request an amendment or correction to your medical record. If you believe that some of your medical information is inaccurate, you may request in writing a request to amend your medical record. We have forms available to you for this purpose. Please feel free to call or write to request a form. Please direct completed form to the Privacy Office. We must respond to you within 60 days.
d. You have a right to restrict the further use or disclosure of your personal health

information. This request limited to those requests that do not interfere with treatment, payment, and other healthcare operations. If our organization believes it can accommodate your request, we will do so.

e. You have the right to receive an accounting of your disclosures of protected health information. If you would like an accounting of your disclosures for the past six years, beginning April 14, 2003, you may request one in writing and direct the request to our Health Information Management Department. We must respond within 60 days.

f. You have the right to revoke an authorization. You have the right to revoke an authorization that you may have signed, however, no longer wish for it to be active. We will recognize your request on the date that we receive your revocation; however, we are not responsible for any uses or disclosures acted on behalf of the authorization prior to the date of your revocation.

6. Complaints

Please understand that we believe your personal health information is private and should be respected at all times. If you believe that your information has not been treated this way, please contact our Privacy Officer or his or her designee either by telephone or mail with the following information so your situation can be addressed and/or investigated.

- Complete name
- Telephone number and best time we can reach you.
- Date of occurrence and your account number, if known.
- Names of people you believe were responsible.
- A detailed description of your complaint.

If you do not want to contact our facility, you may contact the Secretary of the Department of Health and Human Services. Pioneers Medical Center will not retaliate against you for filing a complaint.

7. Contact Information

You may contact our Privacy Officer or his or her designee at (970) 878-5047 if you have any questions or concerns related to this notice or if you wish to report a privacy violation.

8. Effective Date

The notice went into effect on March 3, 2003.

9. Joint Notice

This notice covers more than one healthcare organization. Other healthcare organizations may use or disclose your personal health information, as necessary to carry out treatment, payment, or healthcare operations relating to the organized healthcare arrangement. The other organizations that may use or disclose your information according to this notice include: Pioneers Hospital, Walbridge Memorial Convalescent Wing, aka Walbridge Wing, Meeker Family Health Center, Pioneers Medical Center Home Health.

10. Signatures

By signing this document, I am acknowledging that I have received this document. I also understand that it is my responsibility to review the document and seek for clarification if I do not understand some or all of the content in this notice.

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| _____ | _____ |
| Print Patient's Full Legal Name | Date of Birth |
| _____ | _____ |
| Acknowledging Signature Relationship to Patient | Date |
| _____ | _____ |
| Witness Signature | Date |