

**Notice of Privacy Information Practices**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Junction City – Harrisburg Medical Clinics are committed to preserving the privacy and confidentiality of your health information, which is created and/or maintained at our clinics. State and federal laws and regulations require us to implement policies and procedures to safeguard the privacy of your health information. This Notice will provide you with information regarding our privacy practices and applies to all of your health information created and/or maintained at our clinics, including any information that we receive from other health care providers or facilities. The Notice describes the ways in which we may use or disclose your health information and also describes your rights and our obligations concerning such uses or disclosures.

We reserve the right to change this Notice and to make the revised or changed Notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice, which will identify its effective date, in our clinics.

The privacy practices described in this Notice will be followed by:

1. Any health care professional authorized to enter information into your medical record created and/or maintained at our clinic;
2. All clinic employees, staff, and other service providers who have access to your health information at our clinic.

All of the individuals and/or entities identified above will follow the terms of this Notice. In addition, these individuals and/or entities may share health information with each other for purposes of treatment, payment, or health care operations, as further described in the Notice.

The following section describes different ways that we may use and disclose your health information. Not every use or disclosure in a category will be listed. However, all the ways in which we use or disclose your information will fall within one of the categories.

1. **Treatment.** We may use your health information to provide you with health care treatment and services. We may disclose your health information to doctors, nurses, nursing assistants, medication aides, technicians, medical and nursing students, rehabilitation therapy specialists, or other personnel who are involved in your health care. For example, we may order physical therapy services, refer you to a specialist, or fill a prescription and would share information to coordinate care.
2. **Payment.** We may use or disclose your health information so that we may bill and receive payment from you, an insurance company, or another third party for the health care services you receive from us. We also may disclose health information about you to your health plan in order to obtain prior approval for the services we provide to you, or to determine that your health plan will pay for the treatment.
3. **Health Care Operations.** We may use or disclose your health information in order to perform the necessary administrative, educational, quality assurance and business functions of our office.

**Uses and Disclosures of Health Information In Special Situations**

We may use or disclose your health information in certain special situations as described below. For these situations, you have the right to limit these uses and disclosures as provided for in this Notice.

1. **Appointment Reminders.** We may use or disclose your health information for purposes of contacting you to remind you of a health care appointment.
2. **Treatment Alternatives & Health Related Products & Services.** We may use or disclose your health information for purposes of contacting you to inform you of treatment alternatives or health related products and services that may be of interest to you. For example, if you are diagnosed with a diabetic condition, we may contact you regarding a diabetic instruction class being offered.
3. **Family Members and Friends.** We may disclose your health information to individuals, such as family members and friends, who are involved in your care or who help pay for your care. We may make such disclosures when: (a) we have your verbal agreement to do so; (b) we make such disclosures and you do not object; or (c) we can infer from the

circumstances that you would not object to such disclosures. For example, if your spouse comes into the exam room with you, we will assume that you agree to our disclosure of your information while your spouse is present in the room. We also may disclose your health information to family members or friends in instances when you are unable to agree or object to such disclosures, provided that we feel it is in your best interests to make such disclosures and the disclosures relate to that family member or friend's involvement in your care. For example, if you present to our clinic with an emergency medical condition, we may share information with the family member or friend that comes with you to our clinic. We also may share your health information with a family member or friend who calls us to request a prescription refill for you.

### **Other Permitted Or Required Uses And Disclosures Of Health Information**

There are certain instances in which we may be required or permitted by law to use or disclose your health information without your permission.

1. **As required by law.** We may disclose your health information when required by federal, state, or local law to do so. For example, we are required by the Department of Health & Human Services (HHS) to disclose your health information in order to allow HHS to evaluate whether we are in compliance with the federal privacy regulations.
2. **Public Health Activities.** We may disclose your health information to public health authorities that are authorized by law to receive and collect health information for the purpose of preventing or controlling disease, injury, or disability; or report births, deaths, suspected abuse or neglect, reactions to medications; or to facilitate product recalls.
3. **Health Oversight Activities.** We may disclose your health information to health authorities that are authorized by law to receive and collect health information for audits, investigations, inspections or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.
4. **Judicial or Administrative Proceedings.** We may disclose your health information to courts or administrative agencies charged with the authority to hear and resolve lawsuits or disputes. We may disclose your health information pursuant to a court order, a subpoena, a discovery request, or other lawful process issued by a judge or other person involved in the dispute, subject to all applicable legal requirements.
5. **Worker's Compensation.** We may disclose your health information to worker's compensation programs when your health condition arises out of a work-related illness or injury.
6. **Law Enforcement Official.** We may disclose your health information in response to a request received from a law enforcement official to report a criminal activity or respond to a subpoena, court order, warrant, summons, or similar process.
7. **Coroners, Medical Examiners, and Funeral Directors.** We may disclose your health information to a coroner or medical examiner as for purposes of identifying a deceased individual or to determine the cause of death. We may also disclose your health information to a funeral director for the purpose of carrying out his/her necessary activities.
8. **Organ Procurement Organizations or Tissue Banks.** If you are an organ donor, we may disclose your health information to organizations that handle organ procurement, transplantation, or tissue banking for the purpose of facilitating organ or tissue donation or transplantation.
9. **Research.** We may use or disclose your health information for research purposes under certain limited circumstances. Because all research projects are subject to a special approval process, we will not use or disclose your health information for research purposes until the particular research project for which your health information may be used or disclosed has been approved through this special approval process. However, we may use or disclose your health information to individuals preparing to conduct the research project in order to assist them in identifying patients with specific health care needs who may qualify to participate in the research project. Any use or disclosure of your health information, which is done for the purpose of identifying qualified participants, will be conducted onsite at our facility. In most instances, we will ask for your specific permission to use or disclose your health information if the researcher will have access to your name, address, or other identifying information.
10. **To Avert a Serious Threat to Health or Safety.** We may use or disclose your health information when necessary to prevent a serious threat to the health or safety of you or other individuals.
11. **Military & Veterans.** If you are a member of the armed forces or a veteran, we may use or disclose your health information as required by military command authorities.
12. **National Security & Intelligence Activities.** We may use or disclose your health information to authorized federal officials for the purposes of intelligence, counterintelligence, and other national security activities, as authorized by law.
13. **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may use or disclose your health information to the correctional institution or to the law enforcement official as may be necessary (i) for the institution to provide you with health care; (ii) to protect the health or safety of you or another person; or (iii) for the safety and security of the correctional institution.

### **Uses And Disclosures Pursuant To Your Written Authorization**

Except for the purposes identified above, we will not use or disclose your health information for any other purposes unless we have your specific written authorization. You have the right to revoke a written authorization at any time as long as you do so in writing. If you revoke your authorization, we will no longer use or disclose your health information for the purposes identified in the authorization, except to the extent that we have already taken some action in reliance upon your authorization.

Special written authorization is required for the release of health information regarding HIV, drugs, alcohol, and mental health.

### **Your Rights Regarding Your Health Information**

You have the following rights regarding your health information we create and/or maintain. Requests must be in writing.

1. **Right to Inspect and Copy.** You have the right to inspect and/or request a copy of your health information that may be used to make decisions about your care. We will charge a reasonable cost-based fee for copies that may include labor, copying cost, and postage. We may deny your request to inspect and/or receive a copy of your health information in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed.
2. **Right to Amend.** You have the right to request an amendment of your health information that is maintained by our clinic and is used to make health care decisions for you. We may deny your request for an amendment if it is not properly submitted or does not include a reason to support the request. We may also deny your request if the information sought to be amended: (a) was not created by our clinic, unless the person or entity that created the information is no longer available to make the amendment; (b) is not part of the information that is kept by or for our clinic; (c) is not part of the information which you are permitted to inspect and copy; or (d) is accurate and complete.
3. **Right to Accounting of Disclosures.** You have the right to request an accounting of the disclosures of your health information made by us (but not before April 14, 2003). This accounting will not include disclosures of health information that we made for purposes of treatment, payment, or health care operations or pursuant to a written authorization that you have signed.
4. **Right to Request Restrictions.** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone, such as a family member or friend, who is involved in your care or in the payment of your care. For example, you could ask that we not use or disclose information regarding a particular treatment that you received. We are not required to agree to your request. If we do agree, that agreement must be in writing and signed by you and us.
5. **Right to Request Confidential Communication.** You have the right to request that we communicate with you about your health care in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.
6. **Right to a Paper Copy of this Notice.** You have a right to receive a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

If you have any questions regarding this Notice please contact our Privacy Officer at (541) 998-6750. If you believe your privacy rights have been violated, you may file complaint with our clinic or with the Secretary of the Department of Health and Human Services (HHS). To file a complaint with our clinic, contact our Privacy Officer at 355 West 3<sup>rd</sup> Ave Junction City, OR 97448. The first page of the Notice will contain the effective date any dates of revision.

### **Changes to this Notice**

We reserve the right to change this notice, and make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. You have a right to request and receive a copy of any revised or changed notices.

**If you have read and understand the Privacy Statement above then please sign the Acknowledgement of Receipt of Notice of Privacy Information Practices form on the next page & return it to Junction City Medical Clinic**

**Junction City – Harrisburg Medical Clinics**

**Acknowledgement of Receipt of Notice of Privacy Information Practices**

I, \_\_\_\_\_, acknowledge and agree that I have received a copy of the Junction City – Harrisburg Medical Clinics’ Notice of Privacy Information Practices.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Legal Representative (if applicable)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name of Legal Representative

\_\_\_\_\_  
Relationship to Patient

**For Clinic use only**

Junction City – Harrisburg Medical Clinics made a the following good faith efforts to obtain the above referenced individual’s written acknowledgement of receipt of the Notice of Privacy Information Practices.

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