NOTICE OF PRIVACY 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. WE ARE REQUIRED BY FEDERAL LAW TO PROVIDE YOU WITH THIS NOTICE.

The Privacy Officer may be contacted through Tri-County Community Action Agency Health Center

This Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health and related health care services (referred to as "PHI").

We are required to abide by the terms of this Notice, which we may change from time to time. Any new Notice will be effective for all PHI that we maintain at that time. We will provide you with any revised Notice upon your request of our Privacy Contact.

I. Uses and Disclosures of PHI Without Your Consent for Treatment, Payment and Health Care Operations

PHI may be used and disclosed by your health care provider, our office staff and others outside of our office that are involved in your care and treatment for the purposes of providing and paying for health care services to you. PHI may also be used and disclosed to support practice health care operations. We may also securely share your medical record information electronically with other health care providers who treat you. This kind of sharing is called “Health Information Exchange”. If you don’t want to participate in the Exchange, or would like more information, please tell the receptionist who will assist you. Following are examples of the types of uses and disclosures of PHI for these purposes.

Treatment: We may disclose PHI, as needed, to other providers to whom we refer or in a medical emergency so that the treating practitioner has the information necessary to diagnose and treat you.

Payment: We may disclose PHI, as needed, to obtain payment from your health insurance plan (including Medicare), to determine eligibility or coverage for insurance benefits and to undertake medical necessity and utilization review activities e.g., obtaining approval for a hospital stay.

Health Care Operations: We may disclose PHI, as needed, for certain business activities relating to our practice. These activities include, but are not limited to, quality assurance activities, training medical students who see you in our office, and employee review activities. We may also use a sign-in sheet at the registration desk and may call you by name in the waiting room when it is time to see you. We may use or disclose PHI, as necessary, to contact you to remind you of your appointment. We may also use or disclose PHI, as necessary, to inform you of treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Contact to request if you do not want these materials sent to you. We also

may share PHI with certain businesses that perform various activities (e.g., billing, transcription services) for our practice. In these instances, we will have a written contract in place to protect the privacy of PHI. When you chose to sign up for the Patient Portal, you are allowed to receive your health care information (i.e. communication) from our office and access portions of your medical record on a secure web based system.

II. OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITHOUT YOUR CONSENT FOR OTHER REASONS

We may use or disclose PHI in the following situations without your consent, as required by and in accordance with law.

PUBLIC HEALTH AND OVERSIGHT AGENCIES: We may disclose PHI to the Rhode Island Department of Health ("DOH") and other public health authorities for the purpose of controlling disease. We may disclose mental health and substance abuse data to the State of Rhode Island Department of Behavioral Healthcare, Developmental Disabilities & Hospitals in accordance with our facility licensing agreement. We may disclose PHI to any authority authorized by law to receive reports of child abuse or neglect. In addition, we may disclose PHI to such authority if we believe that you have been a victim of abuse, neglect or domestic violence.

We may also use or disclose P1-11 to a duly authorized public or private entity to assist in disaster relief efforts. We may disclose PHI to a health oversight agency, e.g., the Rhode Island Board of Medical Licensure and Discipline and DOH for activities authorized by law, such as licensure of health care professionals, investigation, and inspections.

COMMUNICABLE DISEASES: We may disclose PHI to a person who may have been exposed by you to a communicable disease.

FOOD AND DRUG ADMINISTRATION ("FDA"): We may disclose PHI to the FDA to report adverse reactions to medications, product defects, and other information, required by and subject to the jurisdiction of the FDA.

LEGAL PROCEEDINGS: We may disclose PHI in the course of any legal proceeding, in response to a court order or, in certain instances, in response to a subpoena so long as you have been duly notified or attempts to notify you have been made according to law.

LAW ENFORCEMENT: We may also disclose PHI to law enforcement authorities, so long as all applicable legal requirements are met.

MEDICAL EXAMINER: We may disclose PHI to a medical examiner, e.g., for identification purposes or determining cause of death.

CRIMINAL ACTIVITY: We may disclose PHI, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

WORKERS' COMPENSATION: We may disclose PHI to comply with workers' compensation laws and other similar programs.

REQUIRED USES AND DISCLOSURES: Under the law, we must make disclosures to you and to the Secretary of the United States Department of Health and Human Services ("Secretary") to investigate or determine our compliance with the federal privacy regulations.

III. YOUR RIGHTS

This Section of the Notice describes your rights with respect to PHI and a brief description of how you may exercise these rights. Please contact our Privacy Contact with any questions or to assert any of your rights.

a. GENERALLY, YOU HAVE THE RIGHT TO INSPECT AND COPY PHI AS LONG AS WE MAINTAIN IT.
There are a few exceptions, however, such as copying psychotherapy notes, any information compiled in anticipation of a lawsuit or other proceeding or as laws specifically prohibit your access to PHI. Depending on the circumstances, a decision to deny access may be reviewable.

b. YOU HAVE THE RIGHT TO REQUEST CERTAIN RESTRICTIONS ON CERTAIN USES AND DISCLOSURES OF PHI.
You may ask us not to use or disclose portions of PHI for the purposes of treatment, payment or healthcare operations. You may also request that portions of PHI not be disclosed to family members or friends who may be involved in your care (upon your consent or as otherwise authorized) or to notify them about your medical condition. Your request must state the specific restriction requested and to whom you want the restriction to apply.

We are not required to agree to a restriction that you may request. If we believe it is in your best interest to permit use and disclosure of PHI, PHI will not be restricted. If we agree to the requested restriction, we will not use or disclose PHI in violation of that restriction unless it is needed to provide emergency treatment.

c. YOU HAVE THE RIGHT TO REQUEST TO RECEIVE CONFIDENTIAL COMMUNICATIONS FROM US BY ALTERNATIVE MEANS OR AT AN ALTERNATIVE LOCATION.
We will accommodate all reasonable requests and we will not request an explanation from you as to the basis for the request.

d. DEPENDING UPON THE CIRCUMSTANCES, YOU MAY HAVE THE RIGHT TO AMEND PHI.
In certain cases; we may deny your request because we believe that the PHI is accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us which we will consider. We may prepare a rebuttal to your statement and provide you with a copy of any such rebuttal.

e. YOU HAVE THE RIGHT TO RECEIVE AN ACCOUNTING OF CERTAIN DISCLOSURES WE HAVE MADE, IF ANY, OF PHI.
This right applies to disclosures for purposes other than treatment, payment or healthcare operations and to any disclosures that you may have authorized. It excludes disclosures prior to April 14, 2003 and

disclosures we may have made to you, to family members or friends involved in your care. The right to receive this accounting is subject to certain exceptions, restrictions and limitations.

f. YOU HAVE THE RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE FROM US, UPON REQUEST, EVEN IF YOU HAVE AGREED TO ACCEPT THIS NOTICE ELECTRONICALLY.

IV. USES AND DISCLOSURES OF PHI BASED UPON YOUR WRITTEN AUTHORIZATION

Other uses and disclosures of PHI will be made only with your written authorization. You may revoke this authorization at any time, in writing, except to the extent that we have taken an action in reliance on the use or disclosure indicated in the authorization, or disclosure is otherwise permitted or required by law.

V. COMPLAINTS

You may file a complaint with us and/or to the Secretary if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Contact of your complaint. Please be assured that we will not retaliate against you, in any way, for filing a complaint. We would appreciate your advising us of any of your concerns first so that we may address them.

You may contact the Privacy Officer at Tri-County Community Action Agency Health Center (401) 519-1940 for further information about the complaint process.

The report of any violation of these regulations may be directed to the U.S. Attorney General for the district of RI at (401) 709-5000.

This Notice was published and becomes effective on February 25th, 2020.

Tri-County Community Action Agency
Helping people. Changing lives.

Patient Name: _____ DOB: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I received the Notice, dated February 18th, 2018 on the date below.

_____ _____

Signature of Patient or Authorized Representative Date

_____

Printed Name