

Resilience Center

Effective Date of this Notice: 05/17/2021

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU* MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION IN ACCORDANCE WITH THE HEALTH INSURANCE PORTABILITY AND Accountability ACT (HIPAA). PLEASE REVIEW IT CAREFULLY.

OUR PLEDGE AND LEGAL DUTY TO PROTECT HEALTH INFORMATION ABOUT YOU*:

The privacy of your health information is important to us. We are required by federal and state laws to protect the privacy of your health information. We refer to this information as “protected health information” or “PHI”. The law requires that we give you notice of our legal duties and privacy practices concerning PHI, including:

- We must protect PHI that we have created or received about your past, present, or future health condition, any health care we provide to you, and payment for your health care.
- We must notify you about how we protect PHI about you.
- We must exercise reasonable diligence to identify breaches of unsecured PHI.
- We must notify you about any breach of unsecured PHI.
- We must notify Health and Human Services of any breach of unsecured PHI.
- We must explain how, when, and why we use and/or disclose PHI about you.
- We may only use and/or disclose PHI as we have described in this Notice.

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 new notice provisions effective for all PHI that we maintain to comply with federal and state regulations or changes in health care policies. We will post a revised notice in our offices, make copies available to you upon request, and post the revised notice on our website.

MINNESOTA PATIENT CONSENT FOR DISCLOSURES

We are required by the laws of the State of Minnesota to obtain a written consent from you for most disclosures of your health information. (Some disclosure is authorized by law.) This consent may be obtained at the beginning of your treatment, during the first delivery of health care services, or at a later point in your care when the need arises to disclose your health information to professionals or entities outside of our organization.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

A. Uses and Disclosures of Your Protected Health Information for Purposes of Treatment, Payment, and Health Care Operations.

Health Care Treatment: We may use and disclose PHI about you to provide, coordinate or manage your health care and related services. This may include communicating with other health care providers regarding your treatment and coordinating and managing the delivery of

* Throughout this document, “you” also applies to your minor child or ward.

health services with others. For example, we may use and disclose PHI about you when you need a prescription, lab work, an x-ray, or other health care services. In addition, we may use and disclose PHI about you when referring you to another health care provider or coordinating care with another health care provider.

Payment: We may use and disclose your medical information to others to bill and collect payment for the treatment and services provided to you. 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, services, and supplies used. Before you receive scheduled services, we may share information about these services with your health plan(s) to check for insurance coverage under your plan or policy and to request approval of payment before we provide the services. We may also share portions of your medical information with the following: 1) Billing departments; 2) Collection departments or agencies; 3) Insurance companies, health plans and their agents that provide your coverage; 4) Utilization review personnel who review the care you received to check that it and the costs associated with it were appropriate for your illness or injury; and 5) Consumer reporting agencies (e.g., credit bureaus).

Health Care Operations: We may use and disclose PHI in performing business activities, which we call “health care operations”. For example: Members of our staff such as the risk or quality improvement manager, or members of our quality assurance team may review information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Our Business Associates: There are some services provided in our organization through contacts with business associates. Examples may include laboratory tests, billing procedures, or others. When these services are contracted, we may disclose limited health information to our business associate so that they can perform the job we've asked them to do. . In addition, there may be business associates such as technology professionals or utility contractors who work within our building and may have the opportunity to view some PHI. We require our business associates to sign a contract ensuring their commitment to protect your PHI consistent with this policy Notice.

B. Uses and Disclosures of Your Protected Health Information that Require Your Authorization.

In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization, different from the Minnesota Patient Consent, directing us to use or disclose your health information to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. We cannot use or

disclose your health information for any reason except those described in this Notice without your written permission.

- *Research:* We may disclose information to external researchers with your authorization, which we will attempt to collect in a manner consistent with applicable state laws.
- *Marketing:* We will not be able to use or disclose your name, contact information or other PHI for purposes of marketing our services or products without your written authorization.

C. Uses and Disclosures of Your Protected Health Information that Require Your Opportunity to Agree or Object.

In the following instances we will provide you the opportunity to agree or object to a use or disclosure of your PHI:

- *Notification:* We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.
- *Communication with Family:* Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, the health information relevant to that person's involvement in your care or payment related to your care.

If you would like to object to our use or disclosure of PHI about you in the above circumstances, please notify your treating professional or our Clinic Coordinator.

D. Use And Disclosure Authorized by Law that Do Not Require Your Consent, Authorization or Opportunity to Agree or Object.

Under certain circumstances we are authorized to use and disclose your health information without obtaining a consent or authorization from you or giving you the opportunity to agree or object. These include:

- When the use and/or disclosure is authorized or required by law. For example, when a disclosure is required by federal, state or local law or other judicial or administrative proceeding.
- When the use and/or disclosure is necessary for public health activities. For example, we may disclose PHI about you if you have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition.
- When the disclosure relates to victims of abuse, neglect or domestic violence.
- When the use and/or disclosure is for health oversight activities. For example, we may disclose PHI about you to a state or federal health oversight agency which is authorized by law to oversee our operations.
- When the disclosure is for judicial and administrative proceedings. For example, we may disclose PHI about you in response to an order of a court or administrative tribunal.

- When the disclosure is for law enforcement purposes. For example, we may disclose PHI about you in order to comply with laws that require the reporting of certain types of wounds or other physical injuries.
- When the use and/or disclosure relates to decedents. For example, we may disclose PHI about you to a coroner or medical examiner, consistent with applicable laws, to carry out their duties.
- When the use and/or disclosure relates to products regulated by the 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.
- When the use and/or disclosure relates to cadaveric organ, eye or tissue donation purposes. Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.
- When the use and/or disclosure relates to Worker's Compensation information: 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.
- When the use and/or disclosure is to avert a serious threat to health or safety. For example, we may disclose PHI about you to prevent or lessen a serious and eminent threat to the health or safety of a person or the public.
- When the use and/or disclosure relates to specialized government functions. For example, we may disclose PHI about you if it relates to military and veterans' activities, national security and intelligence activities, protective services for the President, and medical suitability or determinations of the Department of State.
- When the use and/or disclosure relates to correctional institutions and in other law enforcement custodial situations. For example, in certain circumstances, we may disclose PHI about you to a correctional institution having lawful custody of you.

II. YOUR INDIVIDUAL RIGHTS

A. **Right to Request Restrictions on Uses and Disclosures of PHI.**

You have the right to request that we restrict the use and disclosure of PHI about you. We are not required to agree to your requested restrictions, however, and even if we agree to your request there may be situations in which your restrictions may not be followed. These situations include emergency treatment, disclosures to the Secretary of the Department of Health and Human Services, and uses and disclosures described in subsection I. D of the previous section of this Notice. You may request a restriction by submitting your request in writing to us. We will notify you if we are unable to comply with your request. The following is required for request restrictions on PHI:

- You may request restriction on PHI only if you have paid out of pocket for the health care for which you are seeking the restriction.

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FORM 23000

- You do not have to pay for all service out of pocket to request restrictions on PHI, only for the service you wish to be restricted.
- You must make full payment for the service you seek to be restricted. We must notify you if there is a problem with payment and try to resolve the issue with you.
- Breach of any of these requirements allows Resilience Center to unrestricted use of PHI consistent with this Notice.

B. Right to Request Communications via Alternative Means or to Alternative Locations.

Periodically, we will contact you by phone, email, postcard reminders, or other means to the location identified in our records with appointment reminders, results of tests or other health information about you. You have the right to request that we communicate with you through alternative means or to alternative locations. For example, you may request that we contact you at your work address or phone number or by email. While we are not required to agree with your request, we will make efforts to accommodate reasonable requests. You must submit your request in writing.

C. Right to See and Copy PHI.

You have the right to request to see and receive a copy of PHI contained in clinical, billing and other records used to make decisions about you. Your request must be in writing. We may charge you related fees. Instead of providing you with a full copy of the PHI, we may give you a summary or explanation of the PHI about you, if you agree in advance to the form and cost of the summary or explanation. There are certain situations in which we are not required to comply with your request; one of these situations is when we are providing confidential psychotherapy to a minor child or vulnerable adult. We ask that you refer to Resilience Center's Policies regarding confidentiality. For other requests, we will respond to you in writing, stating why we may not grant your request and proposing other options to meet your needs, as well as describing any rights you may have to request a review of our denial.

D. Right to Request An Amendment to the PHI.

You have the right to request that we make amendments to clinical, financial, and other health-related information that we maintain and use to make decisions about you. Your request must be in writing and must explain your reason(s) for the amendment and, when appropriate, provide supporting documentation. We may deny your request if: 1) the information was not created by us (unless you prove the creator of the information is no longer available to amend the record); 2) the information is not part of the records used to make decisions about you; 3) we believe the information in our records is correct and complete; or 4) you would not have the right to see and copy the record as described in paragraph 3 above. We will tell you in writing the reasons for the denial and describe your rights to give us a written statement disagreeing with the denial. If we accept your request to amend the information, we will make reasonable efforts to inform others of the amendment, including persons you name who have received PHI about you and who need the amendment.

E. Right to Request an Accounting of Disclosures of PHI.

You have the right to a listing of certain disclosures we have made of your PHI. You must request this in writing.

You may ask for disclosures made up to six (6) years before the date of your request). The list will include the date of the disclosure, the name and contact information (at the time of the disclosure) of the person or organization receiving the information, a brief description of the information disclosed, and the purpose of the disclosure. If you request a list of disclosures more than once in 12 months, we may charge you a reasonable fee.

F. Right to Receive a Copy of This Notice.

You have the right to request and receive a paper copy of this Notice at any time. We will provide a copy of this Notice no later than the date you first receive service from us (except for emergency services or when the first contact is not in person, and then we will provide the Notice to you as soon as possible). We will make this Notice available in electronic form and post it in our web site (www.resiliencerochester.com.)

III. QUESTIONS OR COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact our Clinic Coordinator. If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information, or to have us communicate with you by alternative means or at alternative locations, you may file a complaint with the Clinic Coordinator. You can also submit a written complaint to the Minnesota or the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the Minnesota or U.S. Department of Health and Human Services.

Our Contact Information:

Attn: Clinic Coordinator, Resilience Center
3006 Allegro Park Lane SW
Rochester, MN 55902
Phone: 507/540-0894 FAX: 507/281-6852

RESILIENCE CENTER

PATIENT NAME: _____

DATE OF BIRTH: _____

ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have been provided with a copy of the Notice of Privacy Practices.

Signature of Patient/Client or Personal Representative

Date

If signed by personal representative, relationship to patient:

Distribution:

- *Original to the patient record*
- *Copy to patient*