

# 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.**

Federal and state law requires the **City of Wisconsin Rapids Fire Department Ambulance Service** to maintain the privacy of your health information. Federal law also requires us to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices we describe in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until we replace it. Any changes in this notice will be in effect for all health information that we maintain, including health information we created or received before the changes.

## USES AND DISCLOSURES OF HEALTH INFORMATION

Without your authorization, we may use and disclose health information about you for treatment, payment, and health care operations. For example:

**TREATMENT:** We may use your health information for treatment or disclose it to a physician or other health care provider, generally at a hospital, providing treatment to you.

**PAYMENT:** We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to federal privacy rules for its payment activities.

**HEALTH CARE OPERATIONS:** We may use and disclose your health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs and accreditation, certification, or licensing activities. We may disclose your health information to other health care providers or organizations, that are subject to the federal privacy rules and that have a relationship with you, to support some of their health care operations. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.

Without your written authorization, we may further use and disclose health information about you. For example:

**TO YOUR FAMILY AND FRIENDS:** We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, we will obtain your oral permission or will provide you with an opportunity to object to our use or disclosure. If you are not present or are incapacitated, or in an emergency, we may disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may use or disclose information about you to notify or assist in notifying a person involved in your care of your location and general condition.

**DISASTER RELIEF:** We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

**PUBLIC BENEFIT:** We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- as required by law;
- for public health activities, including disease vital statistic reporting, child abuse reporting, Food and Drug Administration oversight, product defect exposure to a communicable disease reporting, and to employers regarding work-related illness or injury;
- to report adult abuse, neglect, or domestic violence;
- to health oversight agencies;
- in response to court & administrative orders and other lawful processes;

- to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on or premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- to coroners, medical examiners, and funeral directors;
- if you are an organ donor, to an organ procurement organization;
- to avert a serious threat to health or safety;
- in connection with certain research activities;
- to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- to correctional institutions regarding inmates; and
- as authorized by state worker's compensation laws.

With your written authorization, we may use your health information or disclose it to anyone for any other purpose. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice. If you give us a written authorization, you may revoke it, in writing, at any time. Your revocation will not affect any uses or disclosures permitted by your authorization while it was in effect.

## PATIENT RIGHTS

**ACCESS:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. If we deny your request you may make a request in writing to obtain access to your health information by sending us a letter to the address at the end of this notice. If you request copies, we will charge you a reasonable cost-based fee that may include labor, copying costs, and postage. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we may—but are not required to—prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this notice for more information about fees.

**DISCLOSURE ACCOUNTING:** You have the right to receive a list or accounting of those disclosures that the City of Wisconsin Rapids has made regarding your health information for purposes other than treatment, payment, health care operations, information provided directly to you, and information disclosed as a result of mandated government functions. Your request must include the time period desired for the accounting, which must be less than a 6-year period beginning after April 14, 2003. The first accounting in a 12-month period is free; other requests may be charged according to our cost for producing the information.

**RESTRICTION:** You have the right to request in writing that we restrict how we use and disclose your medical information. If we agree in writing to the restrictions, we must abide by the agreement (except in an emergency).

**ALTERNATIVE COMMUNICATION:** You have the right to receive your health information through a reasonable alternative means or at an alternative location in a confidential manner, such as sending mail to an address other than your home.

**AMENDMENT:** You have the right to request that we amend your health information. Your request must be in writing, and it must explain why we should amend the information. We may deny your request under certain circumstances, such as when we believe the amended information you provide is incorrect.

## QUESTIONS & COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.

If you are concerned that we violated your privacy rights or you disagree with a decision we made about your access to your health information, you may contact the fire department privacy officer at (715) 423-1150, or the city clerk's office privacy officer at (715) 421-8208. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services Office of Civil Rights. The City of Wisconsin Rapids Fire Department Ambulance Service cannot, and will not, require you to waive the right to file a complaint as a condition of receiving treatment or retaliate against you for filing a complaint with the Secretary of Health and Human Services.

# Acknowledgement of Receipt of Privacy Practices Notice

## Patient or Personal Representative Acknowledgement

### **Section A:** Patient Information.

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Telephone(s): \_\_\_\_\_ E-mail: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

### **Section B:** Acknowledgement of Receipt of Privacy Practices.

I, \_\_\_\_\_, acknowledge that I have received a Notice  
(Printed Name of Patient or Personal Representative)  
of Privacy Practices from the City of Wisconsin Rapids Fire Department Ambulance Service.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If a personal representative signs this authorization on behalf of the individual, complete the following.

Relationship to Individual: \_\_\_\_\_

## **Staff Certification of Good Faith Effort to Obtain Acknowledgement of Receipt**

Describe your good faith effort to obtain the individual's signature on this form:

\_\_\_\_\_  
\_\_\_\_\_

Describe the reason why the individual would not or could not sign this form:

\_\_\_\_\_  
\_\_\_\_\_

### **Staff Member Signature.**

I attest that the above information is correct.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Title: \_\_\_\_\_

(Include this acknowledgement of receipt in the individual's record.)