MARION COUNTY PUBLIC HEALTH DEPARTMENT
Prevent. Promote. Protect.

CLIENT REGISTRATION FORM

Please complete this form so we can provide the best care possible. The information you share with us is part of your **confidential** medical record. Some infectious diseases must be reported to the Indiana State Department of Health in accordance with Indiana state law (IC 16-41-2-1).

PLACE LABEL HERE

PLEASE PRINT

Birth Date: _____ / _____/_____ Social Security Number: _____-_____-_____
MM DD YYYY

Legal Name: _____
First Middle Last

Other names used: _____ Maiden: _____

Address: _____
Street address City State Zip Code

Home phone: (_____) _____ Work phone: (_____) _____ Cell phone: (_____) _____

Email address: _____

Sex/Gender:
☐ Male ☐ Female ☐ Trans (choose one) ☐ male → female ☐ female → male

Marital Status
☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Primary Language:
☐ English ☐ Spanish ☐ Other: _____

Is the patient of a multiple birth? (twin, triplet, etc.) Check the box if the answer is Yes. ☐

Please answer both questions: Please select all that apply. *(This information is for statistical use only)*

1. What is this person's race?
☐ African American or Black
☐ American Indian or Alaskan Native - Specify tribe: _____
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Guamanian or Chamorro
☐ Hawaiian Native
☐ Japanese
☐ Korean
☐ Other Asian: _____
☐ Other Pacific Islander: _____
☐ Other Race: _____
☐ Samoan
☐ Vietnamese
☐ White

2. Is this client Hispanic/Latino?
☐ No, not Spanish/ Hispanic/Latino
☐ Yes, Mexican, Mexican Am., Chicano
☐ Yes, Puerto Rican
☐ Yes, Cuban
☐ Yes, other Spanish/ Hispanic/Latino - Specify: _____

Country of birth:
_____

Insurance Information
Medicaid
ID# _____
Medicare
ID # _____

Smoking Status (Select one if over the age of 12) ❒ Current Smoker ❒ Former Smoker ❒ Never Smoked

Parent or guardian information (if under age 18)

Name: _____ Date of birth: _____ / _____ / _____ Relationship: _____
MM DD YYYY

Address: _____ Phone Number: (_____) _____

In case of emergency, who should be contacted?

Name: _____ Phone Number: (_____) _____

Acknowledgement of receipt of Notice of Privacy

I have received a copy of this office's Notice of Privacy Practices. *(You may refuse to sign this acknowledgement)*

Patient/Parent/Guardian signature: _____ **Date:** _____

Authorization for Services

I hereby authorize the Marion County Public Health Department to examine, test or provide services to the patient listed above. Test results and treatment will be explained to me as part of my visit today. If follow-up is needed or any test/exam results or appointment reminders, I will be contacted by a staff member.

Patient/Parent/Guardian signature: _____ **Date:** _____

HIPAA Refusal: Please complete if client refuses to sign the acknowledgement section. We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

❒ Individual refused to sign ❒ Communication barriers prohibited obtaining the acknowledgement

❒ An emergency situation prevented us from obtaining acknowledgement ❒ Other (please specify)

_____ _____
Authorized Employee Name (Print) Title (Print)

_____ _____
Employee Signature Date

REGISTRATION FORM - PAGE 2

Birth Date: ____/____ / ____
MM DD YYYY

Name: _____
First Middle Last

School Name:_____

Grade: _____

Please list everyone that lives with you

Name	Birthdate	Relationship	Gender	School	(Staff Use) MCPHD#

PATIENT CONTACT AUTHORIZATION

The Marion County Public Health Department allows you to request to receive communications regarding appointments, lab results, treatment and/or other health information. ***Please check all that apply:***

☐ I do not want any contact made.

Telephone Communication

Home Phone _____
☐ OK to leave a detailed voicemail message ☐ Leave message with call back number only ☐ Do not leave a message

Cell Phone _____
☐ OK to leave a detailed voicemail message ☐ Leave message with call back number only ☐ Do not leave a message

Work Phone _____
☐ OK to leave a detailed voicemail message ☐ Leave message with call back number only ☐ Do not leave a message

Other _____
☐ OK to leave a detailed voicemail message ☐ Leave message with call back number only ☐ Do not leave a message

☐ OK to leave a detailed message with: _____ _____
Name Relationship

Written Communication

☐ You may contact me by mail using my home address
☐ You may contact me by mail using my work/office address
☐ If you have any other special request, please list:_____

_____ _____
Patient Signature Date

If you change your mind after completing this authorization, you must submit a written cancellation of the authorization. This will not affect or undo any disclosure prior to this notification.

For Staff Use Only

Date	Additional Addresses	Zip Code	Home Phone	Other Phone

Other Hospital Patient Number: _____ Medicaid Caseworker: _____

MARION COUNTY PUBLIC HEALTH DEPARTMENT
Prevent. Promote. Protect.

Lead Poisoning Prevention Program
3901 Meadows Dr.
Indianapolis, IN 46205
317-221-2155
marionhealth.org

CONSENT TO BLOOD LEAD SCREENING AND AUTHORIZATION TO SHARE INFORMATION FORM

Patient's Information

Please print

Patient's name _____ _____ _____
First Middle Last

Date of birth _____/_____/____
MM DD YYYY

Blood Lead Screening

I understand that a blood screening is necessary because lead poisoning can occur without symptoms. Screening requires a blood sample obtained by a fingerstick or venipuncture.

With a fingerstick, blood is taken from the finger. With a venipuncture, blood is taken from the arm.

If the fingerstick indicates that a *child*'s blood level is elevated, a representative from the Marion County Lead Poison Prevention Program will contact me to schedule a confirmatory test.

Sharing Information

I understand that my/my child's test results are confidential medical information. Under Indiana law, the results of a blood lead test will be shared with other public agencies in a confidential manner. The agencies will take care to protect privacy. Sharing information will help if lead poisoning is identified.

I understand Indiana Code 16-41 -39.4-3 requires the laboratory that analyzes the blood to report the test result and all demographic information to the Indiana State Department of Health (ISDH)

I understand that lead-poisoned children need immediate medical attention. In order to provide this help, ISDH will share this information with other public agencies, which work to prevent and treat lead poisoning. The agencies include the Family and Social Services Administration, the Department of Health and Human Services, the Department of Housing and Urban Development and other housing agencies at the local, state and federal level.

Signature of Verification

By signing below I agree that I have read, understand and authorize the sharing of information regarding my/my child's blood lead screening and test results.

Patient or Parent/Legal guardian (Please print name) _____

Patient or Parent/Legal guardian signature: _____ Date: ____/____/____
MM DD YYYY

For Staff Use Only

Surveyor: _____ Date drawn: ____/____/____
MM DD YYYY

L-17 Lead Safe and Healthy Homes (3/06);revised 6-18 Consent to Blood Lead Screening

THE NOTICE OF PRIVACY PRACTICES FOR PATIENT MEDICAL INFORMATION DESCRIBES:

1. Your rights relative to your protected health information:

- You have the right to keep your PHI confidential.
- You have the right, with some restrictions, to prohibit or restrict the use of your PHI.
- You have the right, with some restrictions, to access, inspect and to obtain copies of your PHI.
- You have the right to amend your PHI for as long as HHC/MCPHD maintains your PHI.
- You have the right to an accounting of your PHI disclosures
- You have the right to pay for services out of pocket and not have any information about those services sent to your insurance company.
- You have the right to submit a complaint if you feel your privacy rights have been violated.

2. HHC/MCPHD's commitment and pledge to protect your rights:

- Your PHI will be protected from disclosure and/or usage as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Additionally, any specific restrictions that you request and are approved will be enforced.

3. How and when your PHI may be used or disclosed by HHC/MCPHD:

- To provide, coordinate or manage your health care by HHC/MCPHD, other health care providers such as doctors, nurses, hospitals, school-based health clinics, and other health facilities, which become involved in your health care.
- For payment of your treatment, services and items you may receive.
- For the explicit use by HHC/MCPHD or our business associates for business operations.
- For specific disclosures required or permitted by law. HHC/MCPHD will only disclose the minimum necessary to comply with the request.
- For health research purposes.
- To provide your PHI to individuals, authorized by you, involved with your care or payment of your care.
- To provide your PHI to a correctional institution or law enforcement official if you are in their custody.
- To provide your PHI, to the extent necessary, to comply with workers' compensation and similar laws providing benefits for work-related injuries or illness.

NOTICE OF PRIVACY PRACTICES FOR PATIENT MEDICAL INFORMATION - *Effective: October 17, 2016*

OUR PLEDGE REGARDING MEDICAL INFORMATION

The Health & Hospital Corporation of Marion County/Marion County Health Department (HHC/MCPHD) is committed to protecting the confidentiality of protected health information (PHI) that HHC/MCPHD collects about you. PHI means any individually identifiable health information which relates to your past, present, or future health treatment or payment for health care services, or for which there is a reasonable basis to believe the information can be used to identify you. This Notice of Privacy Practices (Notice) will tell you how HHC/MCPHD may use and disclose your PHI. This Notice will also tell you about your rights and our duties with respect to your PHI, as well as, how to complain to us if you believe HHC/MCPHD has violated your PHI privacy rights.

WHO IS BOUND BY THIS NOTICE?

This Notice of Privacy Practices describes the practices of HHC/MCPHD as well as that of the following when services are provided at a HHC/MCPHD facility:

- Any health care professional authorized to access or create medical information about you at HHC/MCPHD;
- All divisions, departments and units of HHC/MCPHD;
- All members of a volunteer group whom we allow to assist while you are in a HHC/MCPHD facility;
- All employees, staff, contractors, students, trainees and other personnel working with HHC/MCPHD;
- Medical practitioners and health care professionals of, and faculty practice plans organized under, Indiana University School of Medicine, the Indiana University Medical Group-Primary Care, the Indiana University Medical Group-Specialty Care and the Indiana University Schools of Nursing and Dentistry.
- All health care professionals authorized to provide care on behalf of Eskenazi Health Services, including Eskenazi Hospital, Midtown Mental Health Center, all community health centers and at any other location where Eskenazi Health Services provides services.

All of the above named entities, sites and locations have agreed to follow the terms and conditions of this Notice of Privacy of Practices. In addition, these entities, sites and locations may share your PHI with each other and with HHC/MCPHD for treatment, payment and HHC/MCPHD health care operations as described in this Notice of Privacy Practices.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we may use and disclose your PHI. Not every use or disclosure is listed; however, all of the ways we are permitted to use and disclose PHI fall within one of these categories listed below.

1. Treatment

HHC/MCPHD may use and disclose your PHI to provide, coordinate or manage your health care and related services offered by HHC/MCPHD and other health care providers. HHC/MCPHD may disclose medical information about you to doctors, nurses, hospitals, other health facilities that become involved in your care, and school-based clinics or other school officials involved in a child's care coordination, or continuity of care, when necessary. HHC/MCPHD may consult with other health care providers concerning you, and as part of the consultation, share your PHI with them. Similarly, HHC/MCPHD may refer you to another health care provider and as part of that referral, share medical information about you with that provider. For example, HHC/MCPHD may conclude you need to receive services from a physician with a particular specialty. When HHC/MCPHD refers you to that physician, HHC/MCPHD will provide the medical information requested and deemed necessary for your treatment by that physician.

HHC may participate in various local, regional, state and/or federal Health Information Exchanges ("HIEs") to make certain patient information available electronically to participating hospitals, doctors and others participating in the HIE for purposes of coordinating treatment of care.

2. Payment

HHC/MCPHD may use and disclose your PHI in order to receive payment for the treatment, services and items you may receive. This can include billing you, an insurance company, or a third-party payor. For example, HHC/MCPHD may need to verify that you received certain treatment(s). Also, HHC/MCPHD may be required to provide details regarding your treatment(s) to determine if your benefits will cover or pay for your treatment(s). HHC/MCPHD may work with government programs, such as Medicare or Medicaid, and provide them with information about your medical condition to determine if that program covers you. HHC/MCPHD may also disclose your PHI to obtain payment from third parties that may be responsible for certain costs. HHC/MCPHD may also contact your health plan about a treatment you are going to receive to obtain prior approval for treatment coverage.

3. Health Care Operations

HHC/MCPHD may use and disclose medical information about you for its own business operations. HHC/MCPHD may use and disclose your PHI to evaluate and maintain quality health care services for you. HHC/MCPHD may also use your PHI to study ways to more efficiently manage our organization and provide more cost-efficient services to HHC/MCPHD clients. For example, HHC/MCPHD may disclose your PHI to outside auditing organizations to evaluate the services provided and ensure compliance with the highest industry standards. Whenever possible, we will use medical information that does not identify you.

4. Health-Related Benefits and Services

HHC/MCPHD may use and disclose medical information to keep you informed of health-related benefits or services. For example, HHC/MCPHD may have a new program, treatment alternative or class, which would benefit you. You may write to our HIPAA Privacy Officer at 3838 North Rural Street, Suite 820, Indianapolis, IN 46205, if you do not wish to be contacted for this purpose.

5. Community Service Activities.

HHC/MCPHD may use and disclose your PHI in an effort to provide or refer you to health-related community service activities. We may disclose PHI to members of a business or volunteer group assisting in your receipt of services from HHC/MCPHD. You must write to the Privacy Officer listed in this notice if you do not want to be contacted for community service activities.

6. Business Associates

Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as physicians, copy service companies, record storage facilities, or, etc. At times it may be necessary for us to provide certain health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these business associates to appropriately safeguard the privacy of your information. Business Associates are also required by law to protect your confidentiality and privacy and they sign a contract to this effect.

7. Research

Under certain circumstances, HHC/MCPHD may use and disclose your PHI for research purposes, such as research projects involving patients with specific health problems or taking specific medications. Generally, we will ask you for your specific permission if the researcher will have access to your name, address and other PHI or will be involved in your care. Any research conducted without your expressed permission will have been authorized by a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with clients' need for privacy of their medical information. We may also disclose PHI about a client to people preparing to conduct a research project.

8. HHC/MCPHD Registry

HHC/MCPHD may include your name, general condition (good, fair, serious, critical) and your location in our facility in the HHC/MCPHD site-based registry or sign-in sheet. HHC/MCPHD may disclose this information to people who ask for you by name unless you have previously informed the site/clinic that you do not want this information maintained and/or released.

9. Individuals Involved in Your Care

HHC/MCPHD may use and disclose to a family member, other relative, a close personal friend, or any other person identified and authorized by you, your PHI that is directly relevant to that person's involvement with your care or payment related to your care. HHC/MCPHD also may use or disclose medical information about you to notify those authorized persons of your location, general condition, or death. You have the right to request, in writing, that disclosure of your medical information be prohibited to individuals of your choosing, for example, a family member, other relative, or close personal friend.

10. Disaster Relief

We may use or disclose your PHI to authorized public or private entities to assist with disaster relief efforts or to notify family and friends of your location, condition or death in the event of a disaster.

11. Workers Compensation

HHC/MCPHD may use and disclose PHI about you to the extent necessary to comply with workers' compensation and similar laws that provide benefits for work-related injuries or illness.

12. Fundraising

HHC may contact you to raise money for HHC and its divisions, unless you tell us in writing not to contact you for this purpose. You may write to our HIPAA privacy officer listed in this Notice, if you do not want to be contacted for fundraising.

13. To Avert a Serious Threat to Health or Safety.

We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

14. How HHC Will Contact You

HHC/MCPHD may contact you by telephone or mail at your home or your job in order to remind you of health care appointments, prescription refills, or to reschedule missed or cancelled appointments. HHC/MCPHD may leave messages for you on an answering machine or a voice mail system. You have the right to request, in writing, that HHC/MCPHD communicates your PHI only in a certain way or at a certain location. If reasonable, HHC/MCPHD will accommodate your request. Your request must state specifically how and/or where you wish to be contacted.

DISCLOSURES REQUIRED OR PERMITTED BY LAW

Your permission is not required for the following:

1. As Required by Law: Under certain circumstances, HHC/MCPHD will disclose your PHI when required to do so by federal, state or local law or by regulation. For example, we may disclose your PHI when a law requires that we report information about suspected abuse, neglect, domestic violence, information related to suspected criminal activity, or in response to a court or agency order, subpoena, discovery request or other legal process. Although required to disclose your PHI under any one of these scenarios, HHC/MCPHD will do everything possible to minimize the risk of unauthorized disclosures of your PHI. HHC/MCPHD will only disclose the minimum necessary information to comply with the request. We must also disclose PHI to authorities that monitor compliance with these privacy requirements.

2. Public Health Activities: We may disclose PHI when we are required to collect information about disease or injury, or to report vital statistics to the public health authority, such as reports of tuberculosis cases or births and deaths.

3. Health Oversight Activities: We may disclose your PHI to health oversight agency for activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions.

4. Disclosures for Law Enforcement Purposes: We may disclose your PHI to law enforcement officials for these purposes:

(a) If a crime is committed at a HHC/MCPHD facility;
(b) In response to a court, grand jury or administrative warrant, order or subpoena;
(c) To identify or locate a missing person;
(d) About an actual or suspected victim of a crime if, under certain limited circumstances, we are unable to obtain that person's agreement;
(e) To avert a serious threat or event or to warn a victim or victims of intended harm; or
(f) To report a death if we suspect the death may have resulted from criminal activity

5. Disclosures to Coroners, Medical Examiners and Funeral Directors: We may disclose your PHI to a coroner or medical examiner to identify a deceased person and determine the cause of death. We may also disclose medical information to funeral directors so that they can carry out their duties.

6. Special Government Functions: We may disclose the PHI of military personnel and veterans in certain situations; to correctional facilities in certain situations; and for national security and intelligence reasons, such as protection of the President.

7. Inmates and Persons in Custody: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary:

(1) for the institution to provide you with health care;
(2) to protect your health and safety or the health and safety of others; or
(3) for the safety and security of the correctional institution.

Other Uses of Medical Information

Other uses and disclosures of PHI, not covered by this notice or required by law, will only be made with your written permission or authorization. This includes, but is not limited to, certain uses and disclosures of psychotherapy notes and the sale or use of PHI for marketing purposes. If you provide us permission to use or disclose medical information, you may revoke that permission, in writing, at any time to the Privacy Officer. If you revoke your permission, HHC/MCPHD will no longer use or disclose medical information about you for the reasons covered by your written authorization. HHC/MCPHD will be unable to retract information, used or disclosed or retained in our records of the care we provided to you, prior to your written request.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

You have the following rights regarding your PHI.
All requests must be in writing.

1. Right to Request Restrictions/Alternative Means of Confidential Communications

Under certain circumstances, you have the right to request, in writing, that HHC/MCPHD restrict the uses and disclosures of your PHI. For example, you could ask that HHC/MCPHD not disclose your PHI to a specific family member.

You should explain: (a) what information you want to limit; (b) whether you want to limit use or disclosure or both; and, (c) to whom you want the limits to apply. Additionally, you may request restriction of disclosures to your health plan if it pertains to an item or service paid out of pocket in full and HHC/MCPHD must agree to the requested restriction.

HHC/MCPHD is not required to agree to any requested restriction. However, if HHC/MCPHD does agree, we must follow the restriction unless the information is needed to provide emergency treatment. The restriction will remain in effect for one (1) year from the date restriction is requested, unless otherwise specified.

2. Right to Access, Inspect and Copy

With a few limited exceptions, you have the right to inspect and obtain a copy of your PHI. This includes but is not limited to medical records, laboratory test reports and billing information. To request inspection or copies of your PHI, you must complete, an HHC/MCPHD Authorization for Release of Information form. If electronic health records are maintained by HHC/MCPHD, you may request your PHI in electronic format. Your request should state specifically what PHI you want to inspect or copy. Direct the Authorization to: Marion County Public Health Department, Attention Central Records Department, 3838 N. Rural Street, Room 250, Indianapolis, IN 46205-2930. We will respond to your request within thirty (30) days. If your request is granted, HHC/MCPHD may charge a fee for the costs of copying and mailing. If HHC/MCPHD denies your request, HHC/MCPHD will explain the denial in writing and inform you of any additional rights you may have.

3. Right to Amend

With some exceptions, you also have the right to ask HHC/MCPHD to amend your medical records if you believe they are incomplete or inaccurate. You have this right for as long as HHC/MCPHD maintains your PHI. To request an amendment, you must contact the appropriate service delivery site in writing using the amendment form designated by HHC/MCPHD. Your request must state the amendment(s) desired and provide a detailed reason for the amendment(s). If your request is granted, HHC/MCPHD will add the appropriate amendment(s) and inform others, as needed or required. If HHC denies your request, HHC/MCPHD will explain the denial in writing and inform you of any additional rights you may have.

4. Right to an Accounting of Disclosures

You have a right to request an accounting of disclosures, which is a list of disclosures of your PHI made by HHC/MCPHD for purposes other than treatment, payment or health care operations. Your request can relate to disclosures going as far back as six (6) years. This list will not include those disclosures made to correctional institutions, law enforcement, or national security or intelligence agencies.

To request an accounting of disclosures, your request must be in writing and must state a beginning and ending date for the time period in question. We will respond to your request within 60 days of receiving it.

5. Rights With Respect to Your Insurance

Even if you have insurance, you have the right to pay for services yourself and avoid having any information about these services sent to your insurance company. Also, any genetic information may not be used by your insurance company to make premium rates and coverage decisions about you. HHC/MCPHD will not share the results of any genetic testing with your insurance company.

HHC/MCPHD RESPONSIBILITIES

HHC/MCPHD is required by law to maintain the privacy of your protected health information; notify you promptly if a breach of unsecured PHI occurs that may have compromised the privacy or security of your information; abide by the terms of this Notice or any Notice that is currently in effect; and provide you with a copy of this Notice an our legal duties.

CHANGES TO THIS NOTICE

While HHC/MCPHD reserves the right to change its Notice of Privacy Practices, federal law requires HHC/MCPHD to notify you of any and all changes to that Notice. A copy of our current Notice of Privacy Practices will be posted and made available on the HHC/MCPHD website at www.hhcorp.org and at the HHC/MCPHD headquarters at Health and Hospital Corporation of Marion County, 3838 N. Rural Street, Indianapolis, IN 46205.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with HHC/MCPHD and with the United States Secretary of Health and Human Services. To file a complaint with HHC/MCPHD, send your written complaint to the HHC/MCPHD contact listed below. Your complaint must contain a detailed explanation of the reason(s) for your complaint. To file a complaint with the United States Secretary of Health and Human Services, send your written complaint to: the U.S. Department of Health and Human Services Office for Civil Rights, 200 Independence Avenue, S.W., Washington, D.C. 20201.

We will not retaliate against you or penalize you for filing a complaint.

CONTACT INFORMATION

To contact the HHC/MCPHD for any reason, please send written correspondence to:

HIPAA Privacy Officer
Health and Hospital Corporation of Marion County
3838 N. Rural Street, Suite 820, Indianapolis, IN 46205
317-221-2005

The Health & Hospital Corporation of Marion County complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

HEALTH& HOSPITAL CORPORATION

MARION COUNTY PUBLIC HEALTH DEPARTMENT

Prevent. Promote. Protect.

NOTICE OF PRIVACY PRACTICES FOR PATIENT MEDICAL INFORMATION SUMMARY

Effective: October 17, 2016

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.

The Health & Hospital Corporation of Marion County/ Marion County Public Health Department (HHC/ MCPHD) will protect the confidentiality and security of the patient health information it collects about you. Your protected health information (PHI) includes medical information that specifically identifies you as the patient.

MARION COUNTY PUBLIC HEALTH DEPARTMENT
Prevent. Promote. Protect.

CLIENT REGISTRATION FORM
HOJA DE REGISTRO DEL CLIENTE

Por favor llene esta forma para que nosotros podamos ofrecerle la mejor atención posible. La información que usted comparta con nosotros es parte de su información médica confidencial. Algunas enfermedades infecciosas deben de ser reportadas al Departamento de Salud del Estado de Indiana de acuerdo con la ley estatal (I.C. 16-41-2-1)

Escuelal Nombre: _____

Grado: _____

FOR STAFF USE ONLY

MCPHD Client # _____

Eskenazi Patient# _____

Location or Screening Event _____

POR FAVOR ESCRIBA

Fecha de Nacimiento: _____/_____/_____ (mes / dia / año) Número de Seguro Social: _____ -_____ -_____ (Social Security Number)

Nombre: _____ (Primer nombre / Segundo nombre / Apellido)

Apodo/Sobre nombre: _____ Nombre de soltera: _____

Dirección: _____ (Calle / Ciudad / Estado / Código)

Número de teléfono de la casa: (____) _____ Trabajo: (____) _____ Celular: (____) _____

dirección de correo electrónico: _____

Sexo/Genero:
- ☐ Masculino ☐ Trans (choose one)
- ☐ Femenino ☐ Masculino → Femenino
- ☐ Femenino → Masculino

Estado Marital:
- ☐ Soltero(a) ☐ Viudo(a)
- ☐ Casado(a) ☐ Separado
- ☐ Divorciado(a)

Primer Idioma:
- ☐ Inglés
- ☐ Español
- ☐ Otro: _____

¿Es un paciente nacido de parto múltiple? (gemelos, triples, etc.) Marque el cuadro si la respuesta es. Sí ☐

Favor de contestar ambas preguntas: Favor de seleccionar las respuestas que apliquen. *(Esta información es para uso estadístico solamente)*

1. ¿Cual es su raza?
- ☐ Afro Americano o Negro
- ☐ Indio Americano o Nativo de Alaska e - Especifique la tribu:_____
- ☐ Indio Asiático
- ☐ Chino
- ☐ Filipino
- ☐ Guamani o Chamorro
- ☐ Nativo de Hawai
- ☐ Japonés
- ☐ Coreano
- ☐ Otra parte de Asia: _____
- ☐ Otras Islas Pacíficas: _____
- ☐ Otra Raza: _____
- ☐ Samoano
- ☐ Vietnamita
- ☐ Blanco

2. ¿Es ud hispano/Latino?
- ☐ No, Otro Hispano/ Latino Español
- ☐ Si, Puertorriqueño
- ☐ Si, Cubano
- ☐ Si, Mexicano/México Am./ Chicano
- ☐ Si, Otro Hispano/ Latino Español - Especifique: _____

Información sobre el seguro
Medicaid/Hoosier Health Wise
de ID: _____
Seguro Dental
Compañia:_____
de ID: _____
Subscriber #: _____
Medicare
de ID: _____
Otro Seguro
Compañia: _____
Policy # _____

¿El cliente fuma? (si tiene mas de 12 años)

☐ Actualmente fuma ☐ Fumó antes ☐ Nunca ha fumado

Información del padre o tutor legal (si el paciente es menor de 18 años)

Nombre: _____ Fecha de Nacimiento: _____/_____/_____ (MM / DD / YYYY) Relación: _____

Dirección: _____ Número de teléfono: (____) _____

¿A quién debemos contactar en caso de emergencia?

Nombre: _____ Número de teléfono: (____) _____

Reconocimiento de haber recibido el Aviso sobre Privacidad

Yo he recibido una copia del Aviso de las Prácticas de Privacidad. *(Usted puede rehusarse a firmar este reconocimiento)*

Firma del Paciente/Padre/Madre/ Tutor Legal: _____ **Fecha:** _____

Autorización para Servicios

Por medio de la presente autorizo al Marion County Public Health Department para que examine, realice pruebas y ofrezca servicios al paciente mencionado con anterioridad. Los resultados de los análisis y tratamientos serán explicados como parte de la visita de hoy. Si necesitamos hacerle un seguimiento, o darle los resultados de algún examen, o recordarle alguna cita, le contactaremos por medio de un miembro del Departamento de Salud.

Firma del Paciente/Padre/Madre/ Tutor Legal: _____ **Fecha:** _____

HIPAA Refusal: Please complete if client refuses to sign the acknowledgement section. We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

❑ Individual refused to sign ❑ Communication barriers prohibited obtaining the acknowledgement

❑ An emergency situation prevented us from obtaining acknowledgement ❑ Other (please specify) _____

_____ _____
Authorized Employee Name (Print) Title (Print)

_____ _____
Employee Signature Date

DEPARTAMENTO DE SALUD PUBLICA DEL CONDADO DE MARION
HOJA DE REGISTRO DEL CLIENTE - PAGINA 2

FOR STAFF USE ONLY

_____
MCPHD Client #

_____
Eskenazi Patient#

_____
Location or Screening Event

Fecha de Nacimiento: ____ / _____/ _____
mes día año

Nombre: _____
Primer nombre Segundo nombre Apellido

Por favor escriba todas las personas que viven con usted

Nombre	Fecha de Nacimiento	Relación	Sexo	Escuela	(Staff Use) MCPHD#

AUTORIZACIÓN DE CONTACTO CON EL PACIENTE

El Marion County Public Health Department le permite solicitar que se le dejen mensajes con información sobre los turnos, los resultados de los laboratorios, el tratamiento y/o otra información de salud. ***Por favor marque todas las opciones que corresponda***:

❑ No quiero ningún tipo de contacto.

Comunicación telefónica:

Teléfono de la casa _____
❑ Si, deje un mensaje de correo de voz. ❑ Deje un mensaje con un número para devolver la llamada. ❑ No deje ningún mensaje

Teléfono celular _____
❑ Si, deje un mensaje de correo de voz. ❑ Deje un mensaje con un número para devolver la llamada. ❑ No deje ningún mensaje

Teléfono del trabajo _____
❑ Si, deje un mensaje de correo de voz.. ❑ Deje un mensaje con un número para devolver la llamada. ❑ No deje ningún mensaje

Otro _____
❑ Si, deje un mensaje de correo de voz. ❑ Deje un mensaje con un número para devolver la llamada. ❑ No deje ningún mensaje

❑ Si, deje un mensaje a: _____ _____
Nombre Relación

Comunicación por escrito

❑ Puede contactarme por correo al domicilio de mi casa
❑ Puede contactarme por correo al domicilio de mi casa/oficina
❑ Si tiene algún otro pedido especial por favor especifique: _____

_____ _____
Firma del paciente Fecha

Si cambia de opinión luego de haber completado esta autorización, debe presentar una cancelación por escrito de la autorización. Esto no afectará ni revertirá el significado de ninguna divulgación previa a esta notificación.

Para ser llenado solo por el personal - For Staff Use Only

Date	Additional Addresses	Zip Code	Home Phone	Other Phone

Other Hospital Patient Number: _____ Medicaid Caseworker: _____

MARION COUNTY PUBLIC HEALTH DEPARTMENT
Prevent. Promote. Protect.

Programa de Prevención del Envenenamiento por Plomo
3901 Meadows Dr.
Indianapolis, IN 46205
317-221-2155
marionhealth.org

CONSENTIMIENTO PARA EXAMINAR PLOMO SANGUÍNEO Y AUTORIZACIÓN PARA COMPARTIR FORMULARIO DE INFORMACIÓN

Información del Paciente

Letra de Imprenta

Nombre del Paciente _____ _____ _____
Primero Segundo Apellidos

Fecha de Nacimiento: _____/_____/____
Mes Día Año

Prueba de Detección de Plomo en la Sangre

Entiendo que es necesario realizar un análisis de sangre porque el envenenamiento por plomo puede ocurrir sin síntomas. La detección requiere una muestra obtenida por punción capilar extrayendo sangre del dedo o intravenosa que se extrae sangre del brazo.

Si la punción capilar indica que el nivel sanguíneo de un niño es elevado, un representante del Programa de Prevención de Envenenamiento por Plomo del Condado de Marion se pondrá en contacto conmigo para programar una prueba confirmatoria intravenosa.

Compartiendo Información

Entiendo que los resultados de mi prueba o la de mi hijo son información médica confidencial. Según la ley de Indiana, los resultados de una prueba de plomo en la sangre se compartirán con otras agencias públicas de manera confidencial. Las agencias se encargarán de proteger la privacidad. Compartir esta información ayudará, si se identifica el envenenamiento por plomo.

Entiendo que, el Código de Indiana 16-41 -39.4-3 requiere que el laboratorio que analiza la sangre informe el resultado de la prueba y toda la información demográfica al Departamento de Salud del Estado de Indiana (Siglas en inglés: ISDH)

Entiendo que los niños envenenados con plomo necesitan atención médica inmediata. Con el fin de proporcionar esta ayuda, ISDH compartirá esta información con otras agencias públicas que trabajan para prevenir y tratar el envenenamiento por plomo. tales como la Administración de Servicios Sociales y Familia (Siglas en inglés: FSSA), el Departamento de Salud y Servicios Humanos (Siglas en inglés: DHHS), el Departamento de Vivienda y Desarrollo Urbano (Siglas en inglés: HUD) y otras agencias de vivienda a nivel local, estatal y federal.

Firma de Verificación

Al firmar a continuación estoy de acuerdo en que he leído, entiendo y autorizo compartir información con respecto al examen de detección de plomo en la sangre y los resultados de mi prueba o la de mi hijo.

Nombre del Paciente o Padre/Tutor Legal:_____
(Letra de Imprenta)

Firma del Paciente o Padre/Tutor Legal _____ Fecha: ____/____/____
Mes Día Año

Para Uso Exclusivo del Personal Autorizado

Investigador: _____ Fecha de la Prueba: ____/____/____
Mes Día Año

DISCLOSURES REQUIRED OR PERMITTED BY LAW

Your permission is not required for the following:

1. As Required by Law: Under certain circumstances, HHC/MCPHD will disclose your PHI when required to do so by federal, state or local law or by regulation. For example, we may disclose your PHI when a law requires that we report information about suspected abuse, neglect, domestic violence, information related to suspected criminal activity, or in response to a court or agency order, subpoena, discovery request or other legal process. Although required to disclose your PHI under any one of these scenarios, HHC/MCPHD will do everything possible to minimize the risk of unauthorized disclosures of your PHI. HHC/MCPHD will only disclose the minimum necessary information to comply with the request. We must also disclose PHI to authorities that monitor compliance with these privacy requirements.

2. Public Health Activities: We may disclose PHI when we are required to collect information about disease or injury, or to report vital statistics to the public health authority, such as reports of tuberculosis cases or births and deaths.

3. Health Oversight Activities: We may disclose your PHI to health oversight agency for activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions.

4. Disclosures for Law Enforcement Purposes: We may disclose your PHI to law enforcement officials for these purposes:

(a) If a crime is committed at a HHC/MCPHD facility;
(b) In response to a court, grand jury or administrative warrant, order or subpoena;
(c) To identify or locate a missing person;
(d) About an actual or suspected victim of a crime if, under certain limited circumstances, we are unable to obtain that person's agreement;
(e) To avert a serious threat or event or to warn a victim or victims of intended harm; or
(f) To report a death if we suspect the death may have resulted from criminal activity

5. Disclosures to Coroners, Medical Examiners and Funeral Directors: We may disclose your PHI to a coroner or medical examiner to identify a deceased person and determine the cause of death. We may also disclose medical information to funeral directors so that they can carry out their duties.

6. Special Government Functions: We may disclose the PHI of military personnel and veterans in certain situations; to correctional facilities in certain situations; and for national security and intelligence reasons, such as protection of the President.

7. Inmates and Persons in Custody: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary:

(1) for the institution to provide you with health care;
(2) to protect your health and safety or the health and safety of others; or
(3) for the safety and security of the correctional institution.

Other Uses of Medical Information

Other uses and disclosures of PHI, not covered by this notice or required by law, will only be made with your written permission or authorization. This includes, but is not limited to, certain uses and disclosures of psychotherapy notes and the sale or use of PHI for marketing purposes. If you provide us permission to use or disclose medical information, you may revoke that permission, in writing, at any time to the Privacy Officer. If you revoke your permission, HHC/MCPHD will no longer use or disclose medical information about you for the reasons covered by your written authorization. HHC/MCPHD will be unable to retract information, used or disclosed or retained in our records of the care we provided to you, prior to your written request.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

You have the following rights regarding your PHI.
All requests must be in writing.

1. Right to Request Restrictions/Alternative Means of Confidential Communications

Under certain circumstances, you have the right to request, in writing, that HHC/MCPHD restrict the uses and disclosures of your PHI. For example, you could ask that HHC/MCPHD not disclose your PHI to a specific family member.

You should explain: (a) what information you want to limit; (b) whether you want to limit use or disclosure or both; and, (c) to whom you want the limits to apply. Additionally, you may request restriction of disclosures to your health plan if it pertains to an item or service paid out of pocket in full and HHC/MCPHD must agree to the requested restriction.

HHC/MCPHD is not required to agree to any requested restriction. However, if HHC/MCPHD does agree, we must follow the restriction unless the information is needed to provide emergency treatment. The restriction will remain in effect for one (1) year from the date restriction is requested, unless otherwise specified.

2. Right to Access, Inspect and Copy

With a few limited exceptions, you have the right to inspect and obtain a copy of your PHI. This includes but is not limited to medical records, laboratory test reports and billing information. To request inspection or copies of your PHI, you must complete, an HHC/MCPHD Authorization for Release of Information form. If electronic health records are maintained by HHC/MCPHD, you may request your PHI in electronic format. Your request should state specifically what PHI you want to inspect or copy. Direct the Authorization to: Marion County Public Health Department, Attention Central Records Department, 3838 N. Rural Street, Room 250, Indianapolis, IN 46205-2930. We will respond to your request within thirty (30) days. If your request is granted, HHC/MCPHD may charge a fee for the costs of copying and mailing. If HHC/MCPHD denies your request, HHC/MCPHD will explain the denial in writing and inform you of any additional rights you may have.

3. Right to Amend

With some exceptions, you also have the right to ask HHC/MCPHD to amend your medical records if you believe they are incomplete or inaccurate. You have this right for as long as HHC/MCPHD maintains your PHI. To request an amendment, you must contact the appropriate service delivery site in writing using the amendment form designated by HHC/MCPHD. Your request must state the amendment(s) desired and provide a detailed reason for the amendment(s). If your request is granted, HHC/MCPHD will add the appropriate amendment(s) and inform others, as needed or required. If HHC denies your request, HHC/MCPHD will explain the denial in writing and inform you of any additional rights you may have.

4. Right to an Accounting of Disclosures

You have a right to request an accounting of disclosures, which is a list of disclosures of your PHI made by HHC/MCPHD for purposes other than treatment, payment or health care operations. Your request can relate to disclosures going as far back as six (6) years. This list will not include those disclosures made to correctional institutions, law enforcement, or national security or intelligence agencies.

To request an accounting of disclosures, your request must be in writing and must state a beginning and ending date for the time period in question. We will respond to your request within 60 days of receiving it.

5. Rights With Respect to Your Insurance

Even if you have insurance, you have the right to pay for services yourself and avoid having any information about these services sent to your insurance company. Also, any genetic information may not be used by your insurance company to make premium rates and coverage decisions about you. HHC/MCPHD will not share the results of any genetic testing with your insurance company.

HHC/MCPHD RESPONSIBILITIES

HHC/MCPHD is required by law to maintain the privacy of your protected health information; notify you promptly if a breach of unsecured PHI occurs that may have compromised the privacy or security of your information; abide by the terms of this Notice or any Notice that is currently in effect; and provide you with a copy of this Notice an our legal duties.

CHANGES TO THIS NOTICE

While HHC/MCPHD reserves the right to change its Notice of Privacy Practices, federal law requires HHC/MCPHD to notify you of any and all changes to that Notice. A copy of our current Notice of Privacy Practices will be posted and made available on the HHC/MCPHD website at www.hhcorp.org and at the HHC/MCPHD headquarters at Health and Hospital Corporation of Marion County, 3838 N. Rural Street, Indianapolis, IN 46205.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with HHC/MCPHD and with the United States Secretary of Health and Human Services. To file a complaint with HHC/MCPHD, send your written complaint to the HHC/MCPHD contact listed below. Your complaint must contain a detailed explanation of the reason(s) for your complaint. To file a complaint with the United States Secretary of Health and Human Services, send your written complaint to: the U.S. Department of Health and Human Services Office for Civil Rights, 200 Independence Avenue, S.W., Washington, D.C. 20201.

We will not retaliate against you or penalize you for filing a complaint.

CONTACT INFORMATION

To contact the HHC/MCPHD for any reason, please send written correspondence to:

HIPAA Privacy Officer
Health and Hospital Corporation of Marion County
3838 N. Rural Street, Suite 820, Indianapolis, IN 46205
317-221-2005

The Health & Hospital Corporation of Marion County complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

HEALTH& HOSPITAL CORPORATION

MARION COUNTY PUBLIC HEALTH DEPARTMENT

Prevent. Promote. Protect.

NOTICE OF PRIVACY PRACTICES FOR PATIENT MEDICAL INFORMATION SUMMARY

Effective: October 17, 2016

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.

The Health & Hospital Corporation of Marion County/ Marion County Public Health Department (HHC/ MCPHD) will protect the confidentiality and security of the patient health information it collects about you. Your protected health information (PHI) includes medical information that specifically identifies you as the patient.

THE NOTICE OF PRIVACY PRACTICES FOR PATIENT MEDICAL INFORMATION DESCRIBES:

1. Your rights relative to your protected health information:

- You have the right to keep your PHI confidential.
- You have the right, with some restrictions, to prohibit or restrict the use of your PHI.
- You have the right, with some restrictions, to access, inspect and to obtain copies of your PHI.
- You have the right to amend your PHI for as long as HHC/MCPHD maintains your PHI.
- You have the right to an accounting of your PHI disclosures
- You have the right to pay for services out of pocket and not have any information about those services sent to your insurance company.
- You have the right to submit a complaint if you feel your privacy rights have been violated.

2. HHC/MCPHD's commitment and pledge to protect your rights:

- Your PHI will be protected from disclosure and/or usage as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Additionally, any specific restrictions that you request and are approved will be enforced.

3. How and when your PHI may be used or disclosed by HHC/MCPHD:

- To provide, coordinate or manage your health care by HHC/MCPHD, other health care providers such as doctors, nurses, hospitals, school-based health clinics, and other health facilities, which become involved in your health care.
- For payment of your treatment, services and items you may receive.
- For the explicit use by HHC/MCPHD or our business associates for business operations.
- For specific disclosures required or permitted by law. HHC/MCPHD will only disclose the minimum necessary to comply with the request.
- For health research purposes.
- To provide your PHI to individuals, authorized by you, involved with your care or payment of your care.
- To provide your PHI to a correctional institution or law enforcement official if you are in their custody.
- To provide your PHI, to the extent necessary, to comply with workers' compensation and similar laws providing benefits for work-related injuries or illness.

NOTICE OF PRIVACY PRACTICES FOR PATIENT MEDICAL INFORMATION · *Effective: October 17, 2016*

OUR PLEDGE REGARDING MEDICAL INFORMATION

The Health & Hospital Corporation of Marion County/Marion County Health Department (HHC/MCPHD) is committed to protecting the confidentiality of protected health information (PHI) that HHC/MCPHD collects about you. PHI means any individually identifiable health information which relates to your past, present, or future health treatment or payment for health care services, or for which there is a reasonable basis to believe the information can be used to identify you. This Notice of Privacy Practices (Notice) will tell you how HHC/MCPHD may use and disclose your PHI. This Notice will also tell you about your rights and our duties with respect to your PHI, as well as, how to complain to us if you believe HHC/MCPHD has violated your PHI privacy rights.

WHO IS BOUND BY THIS NOTICE?

This Notice of Privacy Practices describes the practices of HHC/MCPHD as well as that of the following when services are provided at a HHC/MCPHD facility:

- Any health care professional authorized to access or create medical information about you at HHC/MCPHD;
- All divisions, departments and units of HHC/MCPHD;
- All members of a volunteer group whom we allow to assist while you are in a HHC/MCPHD facility;
- All employees, staff, contractors, students, trainees and other personnel working with HHC/MCPHD;
- Medical practitioners and health care professionals of, and faculty practice plans organized under, Indiana University School of Medicine, the Indiana University Medical Group-Primary Care, the Indiana University Medical Group-Specialty Care and the Indiana University Schools of Nursing and Dentistry.
- All health care professionals authorized to provide care on behalf of Eskenazi Health Services, including Eskenazi Hospital, Midtown Mental Health Center, all community health centers and at any other location where Eskenazi Health Services provides services.

All of the above named entities, sites and locations have agreed to follow the terms and conditions of this Notice of Privacy of Practices. In addition, these entities, sites and locations may share your PHI with each other and with HHC/MCPHD for treatment, payment and HHC/MCPHD health care operations as described in this Notice of Privacy Practices.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we may use and disclose your PHI. Not every use or disclosure is listed; however, all of the ways we are permitted to use and disclose PHI fall within one of these categories listed below.

1. Treatment

HHC/MCPHD may use and disclose your PHI to provide, coordinate or manage your health care and related services offered by HHC/MCPHD and other health care providers. HHC/MCPHD may disclose medical information about you to doctors, nurses, hospitals, other health facilities that become involved in your care, and school-based clinics or other school officials involved in a child's care coordination, or continuity of care, when necessary. HHC/MCPHD may consult with other health care providers concerning you, and as part of the consultation, share your PHI with them. Similarly, HHC/MCPHD may refer you to another health care provider and as part of that referral, share medical information about you with that provider. For example, HHC/MCPHD may conclude you need to receive services from a physician with a particular specialty. When HHC/MCPHD refers you to that physician, HHC/MCPHD will provide the medical information requested and deemed necessary for your treatment by that physician.

HHC may participate in various local, regional, state and/or federal Health Information Exchanges ("HIEs") to make certain patient information available electronically to participating hospitals, doctors and others participating in the HIE for purposes of coordinating treatment of care.

2. Payment

HHC/MCPHD may use and disclose your PHI in order to receive payment for the treatment, services and items you may receive. This can include billing you, an insurance company, or a third-party payor. For example, HHC/MCPHD may need to verify that you received certain treatment(s). Also, HHC/MCPHD may be required to provide details regarding your treatment(s) to determine if your benefits will cover or pay for your treatment(s). HHC/MCPHD may work with government programs, such as Medicare or Medicaid, and provide them with information about your medical condition to determine if that program covers you. HHC/MCPHD may also disclose your PHI to obtain payment from third parties that may be responsible for certain costs. HHC/MCPHD may also contact your health plan about a treatment you are going to receive to obtain prior approval for treatment coverage.

3. Health Care Operations

HHC/MCPHD may use and disclose medical information about you for its own business operations. HHC/MCPHD may use and disclose your PHI to evaluate and maintain quality health care services for you. HHC/MCPHD may also use your PHI to study ways to more efficiently manage our organization and provide more cost-efficient services to HHC/MCPHD clients. For example, HHC/MCPHD may disclose your PHI to outside auditing organizations to evaluate the services provided and ensure compliance with the highest industry standards. Whenever possible, we will use medical information that does not identify you.

4. Health-Related Benefits and Services

HHC/MCPHD may use and disclose medical information to keep you informed of health-related benefits or services. For example, HHC/MCPHD may have a new program, treatment alternative or class, which would benefit you. You may write to our HIPAA Privacy Officer at 3838 North Rural Street, Suite 820, Indianapolis, IN 46205, if you do not wish to be contacted for this purpose.

5. Community Service Activities.

HHC/MCPHD may use and disclose your PHI in an effort to provide or refer you to health-related community service activities. We may disclose PHI to members of a business or volunteer group assisting in your receipt of services from HHC/MCPHD. You must write to the Privacy Officer listed In this notice if you do not want to be contacted for community service activities.

6. Business Associates

Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as physicians, copy service companies, record storage facilities, or, etc. At times it may be necessary for us to provide certain health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these business associates to appropriately safeguard the privacy of your information. Business Associates are also required by law to protect your confidentiality and privacy and they sign a contract to this effect.

7. Research

Under certain circumstances, HHC/MCPHD may use and disclose your PHI for research purposes, such as research projects involving patients with specific health problems or taking specific medications. Generally, we will ask you for your specific permission if the researcher will have access to your name, address and other PHI or will be involved in your care. Any research conducted without your expressed permission will have been authorized by a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with clients' need for privacy of their medical information. We may also disclose PHI about a client to people preparing to conduct a research project.

8. HHC/MCPHD Registry

HHC/MCPHD may include your name, general condition (good, fair, serious, critical) and your location in our facility in the HHC/MCPHD site-based registry or sign-in sheet. HHC/MCPHD may disclose this information to people who ask for you by name unless you have previously informed the site/clinic that you do not want this information maintained and/or released.

9. Individuals Involved in Your Care

HHC/MCPHD may use and disclose to a family member, other relative, a close personal friend, or any other person identified and authorized by you, your PHI that is directly relevant to that person's involvement with your care or payment related to your care. HHC/MCPHD also may use or disclose medical information about you to notify those authorized persons of your location, general condition, or death. You have the right to request, in writing, that disclosure of your medical information be prohibited to individuals of your choosing, for example, a family member, other relative, or close personal friend.

10. Disaster Relief

We may use or disclose your PHI to authorized public or private entities to assist with disaster relief efforts or to notify family and friends of your location, condition or death in the event of a disaster.

11. Workers Compensation

HHC/MCPHD may use and disclose PHI about you to the extent necessary to comply with workers' compensation and similar laws that provide benefits for work-related injuries or illness.

12. Fundraising

HHC may contact you to raise money for HHC and its divisions, unless you tell us in writing not to contact you for this purpose. You may write to our HIPAA privacy officer listed in this Notice, if you do not want to be contacted for fundraising.

13. To Avert a Serious Threat to Health or Safety.

We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

14. How HHC Will Contact You

HHC/MCPHD may contact you by telephone or mail at your home or your job in order to remind you of health care appointments, prescription refills, or to reschedule missed or cancelled appointments. HHC/MCPHD may leave messages for you on an answering machine or a voice mail system. You have the right to request, in writing, that HHC/MCPHD communicates your PHI only in a certain way or at a certain location. If reasonable, HHC/MCPHD will accommodate your request. Your request must state specifically how and/or where you wish to be contacted.

DIVULGACIÓN EXIGIDA O PERMITIDA DE ACUERDO CON LA LEY
No se necesita su permiso para lo siguiente:

1. De acuerdo con lo exigido por la ley: En ciertos casos, la HHC/el MCPHD divulgará su PHI cuando así lo exijan las leyes federales, estatales o locales o las regulaciones. Por ejemplo, podemos divulgar su PHI cuando una ley exija que reportemos información si se sospecha abuso, negligencia, violencia doméstica, información relacionada con presunta actividad delictiva o en respuesta a una orden de un tribunal u organismo, citación judicial, petición de pruebas u otro proceso legal. Aunque se solicite a la HHC/el MCPHD divulgar su PHI bajo cualquiera de estas circunstancias, la HHC/el MCPHD hará todo lo posible para disminuir el riesgo de divulgación de su PHI sin su autorización. La HHC/el MCPHD únicamente revelará la información mínima necesaria para atender esta solicitud. También tenemos la obligación de divulgar la PHI a las autoridades que supervisan el cumplimiento de estos requisitos de privacidad.

2. Actividades de salud pública: Podemos revelar su PHI cuando se nos solicite para recopilar información sobre una enfermedad o lesión, o para reportar estadísticas vitales a las autoridades de salud pública, tal como informar casos de tuberculosis, nacimientos o fallecimientos.

3. Actividades de supervisión de salud: Podemos divulgar su PHI a organismos de supervisión de salud para actividades autorizadas legalmente, incluyendo auditorías, investigaciones, inspecciones, otorgamiento de licencias o medidas disciplinarias.

4. Divulgaciones para fines de policiales: Podemos divulgar su PHI a funcionarios policiales para los siguientes fines:

(a) Si se ha cometido un delito en una instalación de la HHC/el MCPHD;
(b) En respuesta a un mandato judicial o administrativo, orden o citación de un tribunal o juzgado superior.
(c) Para identificar o localizar a una persona desaparecida;
(d) Sobre una víctima real o supuesta de un delito si, bajo ciertas circunstancias limitadas, no podemos obtener la autorización de esa persona;
(e) Para prevenir una amenaza o suceso grave o para advertir a la posible víctima o víctimas de la intención de hacerle(s) daño; o
(f) Para reportar una muerte si sospechamos que puede haber sido el resultado de actividades delictivas

5. Divulgación a los funcionarios forenses, médicos forenses y directores de funerarias: Podemos divulgar su PHI a un funcionario forense o médico forense para identificar a una persona fallecida y determinar la causa de muerte. También podemos divulgar información médica a los directores de funerarias para que puedan llevar a cabo sus funciones.

6. Funciones especiales del gobierno: Podemos revela la PHI de personal militar y excombatientes en ciertas situaciones; a las instituciones correccionales en ciertas situaciones y por motivos de seguridad o de inteligencia, tales como para la protección del Presidente.

7. Presos y personas bajo custodia: Si usted es un recluso de una institución correccional o se encuentra bajo la custodia de un funcionario policial, podemos divulgar información médica sobre usted a la institución correccional o al funcionario policial. La divulgación sería según fuese necesario: (1) para que la institución le proporcione atención médica; (2) para proteger su salud y la salud y la seguridad de otros; o (3) para protección y seguridad de la institución correccional.

Otros usos de la información médica

Otros usos y divulgaciones de la PHI, no cubiertos por este aviso o no requeridos por la ley, solo podrán realizarse mediante su permiso o autorización por escrito. Esto incluye pero no está limitado a; ciertos usos o divulgaciones de las notas de la psicoterapia y la venta o el uso de la PHI con fines de mercadeo. Si usted nos autoriza para usar o divulgar la información médica, puede anular ese permiso, por escrito, en cualquier momento al Oficial de privacidad. Si revoca su permiso, HHC/MCPHD no lo utilizará más adelante ni divulgará su información médica por las razones expuestas en su autorización escrita. La HHC/el MCPHD no podrá retraer información que haya sido utilizada, divulgada o retenida en nuestros archivos acerca de los servicios que le suministramos, antes de su solicitud por escrito.

SUS DERECHOS CON RESPECTO A SU INFORMACIÓN MÉDICA.
Usted tiene los siguientes derechos sobre su PHI.
Todas las solicitudes deben ser por escrito.

1. Derecho de solicitar restricciones/ medios alternos de comunicación confidencial: Bajo ciertas circunstancias, tiene el derecho de solicitar, por escrito, que la HHC/el MCPHD restrinja el uso y divulgación de su PHI. Por ejemplo, puede solicitar a la HHC/el MCPHD que no revele su PHI a algún miembro específico de su familia.

Debe explicar: (a) qué información desea limitar; (b) si desea limitar el uso o la divulgación, o ambos; y (c) a quién desea que se le apliquen las limitaciones. Además, puede solicitar la restricción de divulgación de su plan de salud si pertenece a un ítem o servicio pagado en forma directa y total por usted y la HHC/el MCPHD debe aceptar la restricción solicitada.

HHC/MCPHD no está obligada a aprobar una restricción solicitada. Sin embargo, si HHC/MCPHD acepta, debemos cumplir con la restricción, a menos que la información sea necesaria para proporcionar tratamiento de emergencia. La restricción permanecerá en efecto por un año (1) a partir de la fecha en la cual tal restricción fue solicitada, a menos que se especifique de otra manera.

2. Derecho de acceso, inspección y copia: Con ciertas limitadas excepciones, usted tiene el derecho de inspeccionar y obtener copia de su PHI. Esto incluye, entre otros, los registros médicos, los informes de pruebas de laboratorio y la información de facturación. Para solicitar la inspección de copias de su PHI, debe rellenar un formulario de Autorización de divulgación de información de la HHC/el MCPHD. Si la HHC/el MCPHD mantiene registros de salud en formato electrónico, puede solicitar su PHI en formato electrónico. Su petición debe indicar específicamente cuál PHI necesita inspeccionar o copiar. Dirija la autorización a: Marion County Public Health Department, Attention Central Records Department, 3838 N. Rural Street, Room 250, Indianapolis, IN 46205-2930. Responderemos a su solicitud en el plazo de treinta (30) días. Si se aprueba su solicitud, la HHC/el MCPHD le solicitará el pago por concepto de los costos de copia y correo. Si se niega su solicitud, la HHC/el MCPHD le explicará por escrito las razones y le informará de cualquier derecho adicional que pueda tener.

3. Derecho de rectificación: Con algunas excepciones, usted también tiene el derecho de solicitarle a la HHC/MCPHD la rectificación de su historia médica si usted piensa que está incompleta o incorrecta. Usted tiene este derecho mientras la HHC/MCPHD mantenga su PHI. Para solicitar una rectificación, usted debe comunicarse por escrito con el sitio del servicio de entrega que corresponde utilizando el formulario de enmienda establecido por la HHC/el MCPHD. Su petición debe explicar la(s) rectificación(es) deseada(s) y la razón detallada para dicha(s) corrección(es). Si su petición es aprobada, la HHC/el MCPHD agregará la corrección apropiada e informará a quienes lo necesiten o requieran. Si la HHC/MCPHD niega su petición, HHC/MCPHD le explicará por escrito y le informará de algunos otros derechos que usted pueda tener. Si la HHC/el MCPHD niega la petición, le explicará por escrito las razones y le informará de cualquier derecho adicional que pueda tener.

4. Derecho a un informe sobre la cantidad de divulgaciones: Tiene derecho a solicitar a la HHC/el MCPHD un informe de las divulgaciones, el cual es una lista de las divulgaciones de su PHI por parte de la HHC/el MCPHD para fines diferentes de tratamientos, pagos u operaciones de atención médica. Su solicitud puede abarcar divulgaciones que hayan ocurrido en los seis (6) años inmediatamente anteriores. Esta lista no incluirá las divulgaciones realizadas a las instituciones correccionales, policiales, de seguridad nacional u organismos de inteligencia.

Para pedir una relación de las divulgaciones realizadas, su solicitud debe efectuarla por escrito e indicar una fecha de comienzo y una fecha de terminación del periodo en cuestión. Responderemos a su solicitud en el plazo de sesenta (60) días.

5. Derechos con respecto a su seguro: Incluso si dispone de seguro, tiene el derecho de pagar mediante desembolso directo por los servicios que reciba y evitar que se envíe la información de tales servicios a su compañía de seguros. Asimismo, la información genética no puede ser usada por su compañía de seguros para las tarifas de primas ni las decisiones de cobertura sobre usted. La HHC/el MCPHD no compartirá los resultados de las pruebas genéticas con su compañía de seguros.

RESPONSABILIDADES DE LA HHC/EL MCPHD

La ley obliga a la HHC/el MCPHD a mantener la privacidad de su información médica protegida; notificarle rápidamente si ha ocurrido una violación de la PHI no protegida que pueda comprometer la privacidad o la seguridad de su información; cumplir con los términos de esta Notificación o de cualquier Notificación que esté actualmente en vigencia y proporcionarle una copia de esta Notificación y de nuestros deberes legales.

CAMBIOS A ESTA NOTIFICACIÓN

Aunque la HHC/el MCPHD se reserva el derecho de cambiar su Notificción de Procedimientos de Privacidad, la ley federal requiere que la HHC/el MCPHD le notifique los cambios efectuados en la Notificación. Una copia de nuestra Notificación sobre Procedimientos de Privacidad actual será colocada y estará disponible en el sitio web de la HHC/el MCPHD en www.hhcorp.org y en las oficinas principales de la HHC/el MCPHD en la Health and Hospital Corporation de Marion County, 3838 N.Rural Street, Indianápolis, IN 46205.

QUEJAS

Si considera que sus derechos de privacidad han sido violados, puede presentar una queja a la HHC/el MCPHD y a la Secretaría de Salud y Servicios Humanos de los Estados Unidos. Para presentar una queja ante la HHC/el MCPHD, escriba a la dirección que aparece a continuación. Su queja deberá incluir una explicación detallada de la(s) razón(es) para presentarla. Para presentar una queja con la Secretaría de Salud y Servicios Humanos de los Estados Unidos, envíe su queja por escrito a: U.S. Department of Health and Human Services Office for Civil Rights, 200 Independence Avenue, S.W., Washington, D.C. 20201.

Usted no será objeto de represalias ni se le penalizará por presentar una queja.

INFORMACIÓN DE CONTACTO

Para comunicarse con la HHC/el MCPHD por cualquier razón, envíe su correspondencia a:

HIPAA Privacy Officer
Health and Hospital Corporation of Marion County
3838 N. Rural Street, Suite 820, Indianapolis, IN 46205

La Corporación de Salud y Hospitales cumple con todas las leyes federales de derechos civiles y no discrimina en lo que respecta a raza, color, origen nacional, edad, discapacidad ni sexo.

HEALTH& HOSPITAL CORPORATION

MARION COUNTY PUBLIC HEALTH DEPARTMENT

Prevent. Promote. Protect.

NOTIFICACIÓN SOBRE PROCEDIMIENTOS DE PRIVACIDAD REFERENTES A LA HISTORIA MÉDICA DEL PACIENTE

Vigencia: 17 de octubre de 2016

ESTA NOTIFICACIÓN DESCRIBE CÓMO SE PUEDE UTILIZAR Y DIVULGAR SU INFORMACIÓN MÉDICA Y CÓMO PUEDE USTED TENER ACCESO A ESTA

La Corporación de Salud y Hospitales (Health & Hospital Corporation, HHC) / el Departamento de Salud Pública del Condado Marion (Marion County Public Health Department, MCPHD) protegerá la confidencialidad y la seguridad de la Información médica que obtenga sobre usted como paciente. Su Información médica protegida (Protected Health Information, PHI) incluye cualquier información médica que le identifique individualmente como paciente.

LA NOTIFICACIÓN SOBRE PROCEDIMIENTOS DE PRIVACIDAD REFERENTES A LA HISTORIA MÉDICA DEL PACIENTE DESCRIBE:

1. Sus derechos relacionados con su información médica protegida, los cuales son:

- Usted tiene el derecho de mantener la confidencialidad de su PHI.
- Usted tiene el derecho, con algunas restricciones, de prohibir o restringir el uso de su PHI.
- Usted tiene el derecho, con algunas restricciones, de tener acceso, revisar y obtener copias de su PHI.
- Usted tiene el derecho a modificar su PHI mientras que la HHC/MCPHD la conserve en registro.
- Usted tiene el derecho de recibir un informe de la divulgación de su PHI.
- Usted tiene el derecho de pagar por los servicios no cubiertos y de los cuales no tiene Información alguna sobre si dichos pagos fueron enviados a su compañía de seguros.
- Usted tiene el derecho de presentar quejas, si considera que sus derechos de privacidad han sido violados.

2. Compromiso y promesa de HHC/MCPHD de proteger sus derechos:

- Su PHI estará resguardada de divulgación y/o utilización según lo definido por la Ley de Transferencia y Responsabilidad de los Seguros de Salud (Health Insurance Portability and Accountability Act, HIPAA) de 1996. Además, entrarán en vigor las restricciones específicas que usted solicite y que se hayan aprobado.

3. Cómo y cuándo puede la HHC/el MCPHD utilizar o divulgar su PHI:

- Para proporcionar, coordinar o administrar sus cuidados médicos a través de la HHC/el MCPHD u otros proveedores de cuidados, tales como médicos, enfermeras, hospitales, clínicas de salud ubicadas en las escuelas y otras instalaciones de salud involucrados en su atención médica.
- Para el pago de gastos por tratamiento, servicios y artículos que usted pudiera recibir.
- Para el uso explícito por parte de la HHC/el MCPHD o asociados de negocios en lo concerniente a las operaciones comerciales.
- Para divulgaciones específicas requeridas o permitidas legalmente. La HHC/el MCPHD únicamente revelará el mínimo necesario para cumplir con la solicitud.
- Para propósitos de investigación de salud.
- Para proporcionar su PHI a personas, autorizadas por usted, involucradas con su cuidado o con el pago del mismo.
- Para proporcionar su PHI a una institución correccional o funcionario del orden público si usted está bajo su custodia.
- Para proporcionar su PHI, hasta donde sea necesario, de acuerdo con el cumplimiento de las leyes de compensación de trabajadores y similares, que proporcionen beneficios por lesiones o enfermedades relacionadas con el trabajo.

NOTIFICACIÓN SOBRE PROCEDIMIENTOS DE PRIVACIDAD REFERENTES A LA HISTORIA MÉDICA DEL PACIENTE

Vigencia: 17 de octubre de 2016

NUESTRA PROMESA REFERENTE A LA INFORMACIÓN MÉDICA:

La Corporación de Salud y Hospitales (Health and Hospital Corporation, HHC) / el Departamento de Salud Pública del Condado Marion (Marion County Public Health Department, MCPHD) tiene el compromiso de resguardar la confidencialidad de la Información médica protegida (protected health information, PHI) que la HHC/el MCPHD obtiene sobre usted. PHI significa cualquier información médica suya que le identifique individualmente, la cual se relacione con su tratamiento médico o pago por servicios pasados, presentes o futuros, o sobre la cual exista una base razonable para creer que esa información se pueda usar para identificarle. Esta Notificación le explica como la HHC/el MCPHD puede utilizar y revelar su PHI.

Además, esta Notificación sobre Procedimientos de Privacidad le informará de sus derechos y nuestros deberes con respecto a su PHI, así como la forma de presentarnos una queja si considera que la HHC/el MCPHD ha violado sus derechos de privacidad según su PHI.

¿QUIÉN ESTÁ OBLIGADO POR ESTA NOTIFICACIÓN?

Esta Notificación de Procedimientos de Privacidad describe los procedimientos de la HHC/el MCPHD así como también de los siguientes cuando se proporcionen tales servicios en las instalaciones de la HHC/el MCPHD:

- Cualquier profesional de atención médica autorizado para tener acceso o para crear información médica sobre usted en la HHC/el MCPHD;
- Todas las divisiones, departamentos y unidades de la HHC/el MCPHD;
- Todos los miembros de grupos de voluntarios a quienes les permitimos asistir mientras usted esté en las instalaciones de la HHC/el MCPHD;
- Todos los empleados, personal administrativo, contratistas, estudiantes, pasantes y otro personal que trabaje con la HHC/el MCPHD;
- Personal médico y profesionales de atención médica autorizados, y planes de práctica de la facultad organizados en nombre de la Escuela de Medicina, el Grupo de Cuidados Médicos de Atención Primaria, el Grupo de Cuidados Médicos de Atención Especializada, las Escuelas de Enfermería y Odontología de la Universidad de Indiana.
- Todos los profesionales proveedores de atención médica autorizados en nombre de Eskenazi Health Services, incluyendo Eskenazi Hospital, Midtown Mental Health Center, todos los centros comunitarios de salud y cualquier otro sitio en donde Eskenazi Health Services proporcione servicios.

Todas las entidades, sitios y ubicaciones antes mencionados, se han comprometido a cumplir los términos y condiciones de esta Notificación sobre Procedimientos de Privacidad. Además, estas entidades, sitios y ubicaciones pueden compartir su PHI entre ellas y con la HHC/el MCPHD para efectos de tratamiento, pago y operaciones de atención médica de la HHC/el MCPHD tal como se describe en esta Notificación de Procedimientos de Privacidad.

CÓMO PODEMOS UTILIZAR Y DIVULGAR SU INFORMACIÓN MÉDICA:

Las siguientes categorías describen diferentes formas en las cuales podemos utilizar y divulgar su PHI. Sin embargo, no todos los usos o divulgaciones están indicados; todas las formas en las que se nos permite utilizar y divulgar su PHI se encuentran dentro de una de estas categorías mencionadas a continuación:

1. Tratamiento: La HHC/el MCPHD puede utilizar y divulgar su PHI para proporcionar, coordinar o administrar sus cuidados médicos y servicios relacionados ofrecidos por la HHC/el MCPHD y otros proveedores de cuidados de salud. La HHC/el MCPHD puede divulgar información médica acerca de usted a médicos, enfermeros, hospitales y otras instalaciones de salud que estén involucradas en su cuidado, y al personal de clínicas ubicadas en las escuelas u otro oficial en las escuelas involucrados en la coordinación del cuidado de niños o en la continuidad de atención de salud, cuando sea necesario. La HHC/MCPHD puede consultar con otros proveedores de cuidados de salud que le han atendido a usted, y como parte de la consulta compartir su PHI con ellos. Igualmente, la HHC/MCPHD puede referirlo a otro proveedor de cuidados de salud y como parte de tal referencia, compartir su información de salud con tal proveedor. Por ejemplo, la HHC/MCPHD puede concluir que usted necesita los servicios de un médico especializado. Cuando la HHC/MCPHD lo refiere a usted a tal médico, la HHC/MCPHD le proporcionará la información médica solicitada y considerada necesaria para su tratamiento por ese médico.

La HHC puede participar en varios Intercambios de Información de Salud (Health Information Exchanges, HIE) a nivel local, regional, estatal y/o federal para contar con cierta información de pacientes dispuesta electrónicamente a fin de poder notificarle a hospitales, médicos y otros participantes en el HIE, para propósitos de coordinación del tratamiento de cuidado de salud.

2. Pago: La HHC/el MCPHD puede utilizar y divulgar su PHI con el fin de recibir el pago por su tratamiento, servicios y artículos que se le proporcionen. Esto puede incluir facturarle a usted, a la compañía de seguros o a un tercero. Por ejemplo, la HHC/el MCPHD puede verificar si usted recibió cierto(s) tratamiento(s). También, a la HHC/el MCPHD le pueden exigir que suministre detalles referentes a su(s) tratamiento(s) para determinar si sus beneficios cubren o pagan su(s) tratamiento(s). La HHC/el MCPHD puede trabajar con programas del gobierno tales como Medicaid o Medicare, y suministrarles información acerca de su condición médica para determinar si usted está amparado por ese programa. La HHC/el MCPHD también puede divulgar su PHI para obtener el pago de terceros que puedan ser responsables de ciertos costos. La HHC/el MCPHD también puede comunicarse con su plan de salud acerca de un tratamiento que usted va a recibir, para obtener la aprobación previa de este.

3. Transacciones comerciales sobre la atención médica: La HHC/el MCPHD puede utilizar y divulgar información médica relativa a usted para sus propias operaciones financieras. La HHC/el MCPHD puede utilizar y revelar su PHI para evaluar y mantener la calidad de los servicios que se le prestan. La HHC/el MCPHD puede también utilizar su PHI para estudiar métodos para manejar más eficazmente nuestra organización y prestar servicios más eficientes en cuanto al costo para los clientes de la HHC/el MCPHD. Por ejemplo, la HHC/el MCPHD puede divulgar su PHI a organizaciones de auditoría externa para evaluar los servicios suministrados y asegurar el cumplimiento con los estándares más altos de la industria. Siempre que sea posible, utilizaremos la información médica que no lo identifique.

4. Servicios y beneficios relacionados con la salud: La HHC/el MCPHD puede utilizar y divulgar la información médica para informarle sobre beneficios o servicios relacionados con la salud. Por ejemplo, la HHC/el MCPHD puede tener un nuevo programa, tratamiento o clase alternativa, la cual podría beneficiarle. Puede escribir a su Funcionario para la privacidad de la Ley de transferencia y responsabilidad de los seguros médicos (Health Insurance Portability and Accountability Act, HIPAA) al 3838 North Rural Street, Suite 820, Indianapolis, IN 46205, si no desea que se comuniquen con usted para este fin.

5. Actividades de servicio en la comunidad: La HHC/el MCPHD puede utilizar y divulgar su PHI en un esfuerzo de proporcionarle o referirle a actividades de servicio en la comunidad relacionados con la salud. Podemos divulgar su PHI a miembros de negocios o grupos voluntarios que le asisten para que reciba los servicios de la HHC/MCPHD. Usted debe escribir al Oficial de Privacidad listado en este aviso si no quiere ser contactado para lo concerniente a actividades de servicio en la comunidad.

6. Socios comerciales: Ciertos aspectos y componentes de nuestros servicios se realizan a través de contratos con personas u organizaciones externas, tales como médicos, empresas de servicios de copiado, instalaciones para el almacenaje de registros, etc. En algunas ocasiones puede ser necesario que proporcionemos cierta información de salud a una o más de estas personas u organizaciones externas quienes nos asisten en la prestación de servicios relacionados con la salud. En todos los casos, exigimos a estos asociados comerciales que resguarden adecuadamente la privacidad de su información. A los asociados comerciales también se les exige por ley que protejan su confidencialidad y privacidad y que firmen un contrato a tal efecto.

7. Investigación: Bajo ciertas circunstancias, la HHC/el MCPHD puede utilizar y divulgar su PHI con fines de investigación tales como proyectos de investigación que involucren a pacientes con problemas específicos de salud o con medicinas específicas. Por lo general, le pediremos su permiso específico si el investigador va a tener acceso a su nombre, dirección y otra PHI o estará involucrado con su atención médica. Cualquier investigación que se lleve a cabo sin su permiso expreso habrá sido autorizada por un proceso de aprobación especial. Este proceso evalúa un proyecto de investigación propuesto y el uso de información médica, tratando de equilibrar las necesidades de investigación con las del cliente para la privacidad de su información médica. También podemos revelar la PHI sobre un cliente a personas que se estén preparando para llevar a cabo un proyecto de investigación.

8. Registro de la HHC/el MCPHD: La HHC/el MCPHD puede incluir su nombre, condición general (buena, favorable, grave o crítica, y su ubicación dentro de nuestras instalaciones, en el registro de la base de datos de la HHC/el MCPHD o en la hoja de ingreso. La HHC/el MCPHD puede divulgar esta información a personas que pregunten por usted indicando su nombre, a menos que usted haya informado con anticipación en el sitio/clínica que no desea que se mantenga ni divulgue esta información.

9. Personas involucradas en su atención: La HHC/el MCPHD puede utilizar y divulgar su PHI a un miembro de la familia, a otro familiar, a un amigo cercano, o a cualquier otra persona identificada y autorizada por usted, la PHI que sea relevante directamente en relación a su atención médica o al pago relacionado con el servicio médico. La HHC/el MCPHD también puede utilizar o divulgar información médica relacionada con usted para notificar a aquellas personas autorizadas, acerca de su ubicación, su condición general o su muerte. Usted tiene el derecho a solicitar, por escrito, la prohibición de que se divulgue su historia médica a ciertas personas que usted escoja, por ejemplo, un familiar, otro pariente o un amigo personal.

10. En casos de catástrofes: Podemos utilizar o divulgar su PHI a las entidades públicas o privadas autorizadas para asistir en casos de catástrofes o para notificar a familiares y amigos de su ubicación, condición o muerte en caso de una catástrofe.

11. Ley de indemnización laboral: La HHC/el MCPHD puede utilizar su PHI, hasta donde sea necesario, para cumplir con las leyes de indemnización laboral y similares, que proporcionen beneficios por lesiones o enfermedades relacionadas con el trabajo.

12. Recaudación de fondos: La HHC puede comunicarse con usted a fin de recaudar dinero para la HHC y sus divisiones, a menos que usted nos informe por escrito que no le contactemos para este propósito. Usted puede escribir a nuestro Oficial de Privacidad de HIPAA listado en este aviso, si no quiere ser contactado para participar en la recaudación de fondos.

13. Para evitar una amenaza grave a la salud o la seguridad: Podemos utilizar y divulgar información médica sobre usted cuando sea necesario para prevenir una amenaza grave a su salud y seguridad o a la salud y seguridad del público o de otra persona. La divulgación, no obstante, sería solo a la persona capaz de ayudar a prevenir la amenaza.

14. Cómo la HHC se comunicará con usted: La HHC/el MCPHD se puede comunicar con usted por teléfono o por correo a su domicilio o lugar de trabajo con el fin de recordarle sus citas, el reabastecimiento de sus medicamentos recetados o para reprogramar las citas a las cuales no asistió o que fueron canceladas. La HHC/el MCPHD le dejará mensajes en su máquina contestadora o su correo de voz. Usted tiene el derecho de solicitar, por escrito, que la HHC/el MCPHD comunique su PHI solamente de cierta manera o a cierto lugar. Si fuese razonable, la HHC/el MCPHD cumplirá con su solicitud. Su solicitud deberá establecer específicamente cómo y dónde desea que le contacten.