Rishavena
Home Health Care
1338 East 69th Street Brooklyn NY 11234
Tel: 718-251-1231
BRINGING QUALITY CARE TO YOUR HOME

PRIVACY NOTICE

As required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPPA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR IDENTIFIABLE HEALTH INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our organization is dedicated to maintaining the privacy of your identifiable health information. In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and privacy practices concerning your identifiable health information. By law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

To summarize, this notice provides you with the following important information:

- How we may use and disclose your identifiable health information
- Your privacy rights in your identifiable health information
- Our obligations concerning the use and disclosure of your identifiable health information

The terms of this notice apply to all records containing your identifiable health information that are created or retained by our practice. We reserve the right to revise or amend our notice of privacy practices. Any revision or amendment to this notice will be effective for all of your records we may create of maintain in the future. Our organization will post a copy of our current notice in our offices in a prominent location, and you may request a copy of our most current notice during any office visit. **IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT THE New York STATE COUNTY HEALTH DEPARTMENT IN THE COUNTY THAT THE INDIVIDUAL RESIDES AT.**

WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION FOR

1. **Treatment.** Our organization may use your identifiable health information to treat you. For example, we may ask you to undergo laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. Many of the people who work for our organization may use or disclose your identifiable health information in order to treat you or to assist others in your treatment. Additionally, we may disclose your identifiable health information to others who may assist in your care, such as your physician, spouse, children or parents.
2. **Payment**. Our organization may use and disclose you identifiable health information in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will over, or pay for, your treatment. We also may use and disclose your identifiable health information to obtain payment from third parties that may be responsible for such costs, such as family members. Also we may use your identifiable health information to bill you directly for services and items.

3. Health Care Operations. Our organization may use and disclose your identifiable health information to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our organization may use your health information to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice.

OPTIONAL:

4. Appointment Reminders. Our organization may use and disclose your identifiable health information to contact you and remind you of visits/deliveries.

OPTIONAL:

5. Health-Related Benefits and Services. Our organization may use and disclose your identifiable health information to inform you of health-related benefits of services that may be of interest to you.

OPTIONAL:

6. Release of Information to Family/Friends. Our organization may release your identifiable health information to a friend or family member that is helping you pay for your health care, or who assists in taking care of you.

7. Disclosure Required By Law. Our organization will use and disclose your identifiable health information when we are required to do so by federal, state or local law.

A. **USE AND DISCLOSURE OF YOUR IDENTIFIABLE HEALTH INFORMATION IN CERTAIN SPECIAL CIRCUMSTANCES**

1. Public Health Risks. Our organization may disclose your identifiable health information to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths
- Reporting child abuse or neglect
- Preventing or controlling disease, injury or disability
- Notifying a person regarding potential exposure to a communicable disease
- Notifying a person regarding a potential risk for spreading of contracting a disease or condition
- Reporting reactions to drugs or problems with products or devices
- Notifying individuals if a product or device they may be using has been recalled
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agres or we are required or authorized by law to disclose this information
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our organization may disclose your identifiable health information to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and

criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our organization may disclose your identifiable health information in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your identifiable health information in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release identifiable health information if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe might have resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identify or location of the perpetrator)

5. Serious Threats to Health or Safety. Our organization may disclose your identifiable health Information when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

6. Military. Our organization may disclose your identifiable health information if you are a member of U.S or foreign military forces (including veterans) and if required by the appropriate military command authorities.

7. National Security. Our organization may disclose your identifiable health information to federal officials for intelligence and national security activities authorized by law. We also may disclose your identifiable health information to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

8. Inmates. Our organization may disclose your identifiable health information to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

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9. Workers' Compensation Our organization may disclose your identifiable health information for workers' compensation and similar programs.

YOUR RIGHTS REGARDING YOUR IDENTIFIABLE HEALTH INFORMATION

Confidential Communications. You have the right to request that our organization communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to the agency specifying the requested method of contact, or the location where you wish to be contacted. Our organization will accommodate **reasonable** requests. You do not need to give a reason for your request.

1. **Requesting Restrictions**. You have the right to request a restriction in our use or disclosure of your identifiable health information for treatment, payment or health care operations. Additionally, you have the right to request that we limit our disclosure of your identifiable health information to individuals involved in your care or the payment for your care, such as family members and friends. **We are required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your identifiable health information, you must make your request in writing to the agency. Your request must describe in a clear and concise fashion: (a) the information you wish restricted; (b) whether you are requesting to limit our practice's use, disclosure or both; and (c) to whom you want the limits to apply.

2. **Inspection and Copies**. You have the right to inspect and obtain a copy of the identifiable health information that may be used to make decisions about you, including patient medical records and billig records, but not including psychotherapy notes. You must submit your request in writing to the agency in order to inspect and/or obtain a copy of your identifiable health information. Our organization may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Reviews will be conducted by another licensed health care professional chosen by us.

3. **Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our organization. To request an amendment, your request must be made in writing and submitted to the agency. You must provide us with a reason that supports your request for amendment. Our organization will deny any request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is: (a) accurate and complete; (b) not part of the identifiable health information kept by or for the organization; (c) not part of the identifiable health information which you would be permitted to inspect and copy; or (d) not created by our organization, unless the individual or entity that created the information is not available to amend the information.

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4. **Accounting of disclosures**. All of our patients have the right to request an "accounting of disclosures."

An "accounting of disclosures" is a list of certain disclosures our organization has made of your identifiable health information. In order to obtain an accounting of disclosures, you must submit your request in writing to the agency. All requests for an "accounting of disclosures" must state a time period which may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a 12 month period is free of charge, but our practice may charge you for additional lists within the same 12 month period. Our organization will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

5. **Right to a Paper Copy of This Notice**. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, the New York State county Health Department in the county that the individual resides at.

6. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our organization or with the Secretary of the Department of Health and Human Services.

To file a complaint with our organization, contact us. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

7. **Right to Provide an Authorization for Other Uses and Disclosures.** Our organization will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your identifiable health information may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your identifiable health information for the reasons described in the authorization. We are required to retain records of your care.

Acknowledgement of Receipt of the Privacy Notice

Date _____

I have received the agency's Privacy Notice. My questions regarding this notice have been answered. I know that I can contact the Privacy Officer,

_____

_____
Signature

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Date	Info Disclosed	To Whom	Organization Reason	Release? (Yes or No)

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Re: _____
Name

DISCLOSURE FORM

AUTHORIZATION For the agency to:

Use and Disclose Health Information

I understand that this organization wishes to use or disclose the following protected health information:
_____
___
_____
___
_____
___

I understand that the following person or class of persons is authorized to use or disclose this protected health information:
_____
__

I understand that this information will be used or disclosed to:
_____
___
_____
___
_____
___

I understand that this authorization expires on _____
(Insert date or event)

I understand that I may revoke this authorization in writing.

_____ _____
Signature of Patient or Legal Representative Witness

_____ _____
Date Effective Date

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This authorization was obtained verbally, by me, on this date after reading this completed form to the person giving permission for disclosure.

_____ _____

Signature of Patient Obtaining Permission for Disclosure Date

_____ _____

Witness Date