

Notice of Privacy Practices

WOOD DALE FIRE PROTECTION DISTRICT #1

**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

If you have any questions about this notice, please contact Battalion Chief of Training/Safety at 630-766-1147 or 589 N. Wood Dale Rd. Wood Dale, Illinois 60191

WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees.

YOU'RE HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status and the health care and service you receive by the district. We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU FOR TREATMENT

We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health. For example, this includes such things as verbal and written information that we may obtain about you and use pertaining to your medical condition and treatment provided to you by us and other medical personnel (including doctors and nurses who give orders to allow us to provide treatment to you). It also includes information we give to other health care personnel to whom we transfer your care and treatment, and includes transfer of personal health information via radio or telephone to the hospital or dispatch center as well as providing the hospital with a copy of the written record we create in the course of providing you with treatment and transport. Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care. Family members and other health care providers may be part of your medical and may require information about you that we have.

For Payment

We may use and disclose health information about you so that the treatment and service you receive may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a service you received so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

For Health Care Operations

We may and disclose health information about you for operation and to make sure that you and other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help decide what additional services we should offer, how we can be more efficient, or whether certain new treatments are effective.

SPECIAL SITUATIONS

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations.

To Avert a Serious Threat to Health or Safety

We may use and disclose health 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.

Required by Law

We will disclose health information about you when required to do so by federal, state or local law.

Research

We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

Organ and Tissue Donation

If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

Military, Veterans, National Security and Intelligence

If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation

We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks

We may disclose health information about you for public health reason in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Health Oversight Activities

We may disclose health information to a health oversight agency for audits, investigations, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes

If you are involved in a lawsuit or dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

Law Enforcement

We may disclose health information if asked to do so by law a enforcement official in response to a court order, subpoena , warrant, summons, or similar process, subject to all applicable legal requirements.

Coroners, Medical Examiners and Funeral Directors

We may disclose health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine cause of death.

Information Not Personally Identifiable

We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Family and Friends

We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you did not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization*. We must obtain your *Authorization* separate from any *Consent* we may have obtained from you. If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization*, in writing at any time. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission.

If we have HIV or substance abuse information about you, we cannot release that information without a special signed written authorization (different than the *Authorization* and *Consent* mentioned above) from you. In order to disclose these types of records for purposes of treatment, payment or health care operations, we will have to have both your signed *Consent* and special written *Authorization* that complies with the law governing HIV or Substance abuse records.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy

You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to the Battalion Chief of Training/Safety in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to Amend

If you believe the health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office. To request an amendment, complete and submit a Medical Record Amendment/Correction Form to the Battalion Chief of Training/Safety. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- a) We did not create, unless the person or entity that created the information is no longer available to make the amendment
- b) Is not part of the health information that we keep.
- c) You would not be permitted to inspect and copy
- d) Is accurate and complete.

Accounting of Disclosures

You have the right to request an "accounting of disclosures". This is a list of the disclosures we made of medical information about you for the purposes other than treatment, payment and health care operation. To obtain this list, you must submit your request in writing to the Battalion Chief of Training/Safety. It must state a time period, which may not be longer than six years and may not include dates prior to April 14, 2003. Your request should indicate in what form you want the list (for example, on paper electronically). We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions

You have a right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family or a friend.

We are Not Required to Agree to your Request

If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you may complete and submit the *Request for Restriction On Use/Disclosure of Medical Information* to the Battalion Chief of Training/Safety.

Right to Request Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request a confidential communications, you may complete and submit the *Request for Restriction on Use/Disclosure of Medical Information and/or Confidential Communication* to the Battalion Chief of Training/Safety. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of this Notice

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact Battalion Chief of Training/Safety.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

COMPLAINTS

If you believe your privacy right has been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the Battalion Chief of Training/Safety at 630-766-1147 or 589 N. Wood Dale Rd. Wood Dale, Illinois 60191

You will not be penalized for filing a complaint.

Billing Authorization, Responsibility for Payment and Receipt of Notice of Privacy Rights

I understand that I am financially responsible for the service provided to me by the Wood Dale Fire Protection District # 1 regardless of insurance coverage. I request the payment of authorized Medicare or other insurance benefits be made on my behalf to the Wood Dale Fire Protection District # 1.

I authorize and direct any holder of medical information or documentation about me to release to the Centers for Medicare and Medicaid Services and its carriers and agents, as well as to Wood Dale Fire Protection District # 1 and its billing agents and other payers of insurers, any information or documentation needed to determine these benefits or benefits payable for any services provided to me by the Wood Dale Fire Protection District #1, now or in the future. I agree to immediately remit to the Wood Dale Fire Protection District #1 any payments that I receive directly from any source for the service provided to me and I assign all rights to such payments to the Wood Dale Fire Protection District #1.

I also acknowledge that I have received a copy of the Wood Dale Fire Protection District #1 Notice of Privacy Practices. A copy of this form is as valid as the original.

Date:

Print Name of Patient

Signature or Patient or Patient's Representative

Relationship to Patient

Street Address

City, State, Zip