

NOTICE OF PRIVACY PRACTICES & ACKNOWLEDGMENT OF RECEIPT

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY, SIGN THE ACKNOWLEDGEMENT OF RECEIPT, AND GIVE TO THE RECEPTIONIST.

Protecting Your Personal and Health Information

MSU's Healthcare Components (hereinafter "MSUHCC" are committed to protecting the privacy of its patients' health information. MSUHCC is required by law to maintain the privacy of protected health information, to provide individuals with notice of its legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This Notice explains the privacy practices, legal duties, and your rights concerning your health information held by MSUHCC. In this Notice your health information is referred to as "health information" and includes information regarding your health care and treatment with identifiable factors including your name, age, address, income or other financial information. MSUHCC is required to abide by the terms of the Notice of Privacy Practices in effect as required by 45 C.F.R. 164.520(b)(v)(B).

This Notice takes effect **April 3, 2014** and will remain in effect until replaced.

Uses and Disclosures of Your Health Information

We will use and disclose health information about you for treatment, payment and health care operations. For example:

Treatment: We may provide another physician or subsequent healthcare provider who is treating you with copies of your treatment records to assist him or her with your treatment.

Payment: We may disclose your health information to obtain payment by Medicare or private party payors for services we provide to you.

Your Authorization: In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare under HIPAA, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative,

or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing without a written authorization from you.

Required by Law: We may use or disclose your health information when we are required to do so by law, including, but not limited to, court or administrative orders, subpoenas, discovery requests, or other lawful process.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose health information to a correctional institution or law enforcement official having lawful custody of protected health information of an inmate or patient under certain circumstances.

Appointment Reminders: We may also use health information about you to call, leave a voice message, or send a postcard or letter to you as a reminder about an appointment.

Research: Under certain limited circumstances, we may use and disclose health information about you for research purposes. All research projects, however, are subject to a special approval process through MSU's Institutional Review Board.

Miscellaneous. We may also disclose your health information when there is a serious threat to health or safety of a person or to the public, or in connection with disaster relief efforts, workers compensation programs, public health activities, health care oversight, to coroners, medical examiners and funeral directors, the facilitation of organ/tissue donation, military/veteran benefits, protective Services for the President and others, and for use in civil, criminal, or administrative actions or proceedings or in anticipation of litigation).

Selling Protected Health Information (PHI) or Electronic Health Records (EHR): We will not sell your PHI or EHR without your prior authorization.

Rights You Have Regarding the Use and Disclosure of Your Health Information. You have the right to request all of the following:

Access to Your Health Information: You have the right to inspect, copy and request a copy of your health information subject to certain exceptions permitted by HIPAA. A nominal fee may be charged for providing copies. Access to your records may also be limited if it is determined that by providing the information it could possibly be harmful to you or another person. If access is limited for this reason, you have a right to request a review of that decision.

Amendment: You have the right to request in writing an amendment to your health information. The request must identify which information is incorrect and an explanation of why you think it should be amended. If the request is denied, a written explanation stating why will be provided to you. You may also make a statement disagreeing with the denial which will be added to the information of the original request. If your original request is approved, we will make reasonable effort to include the amended information in future disclosures. (Amending a record does not mean that any portion of your health information will be deleted.)

Accounting of Disclosures: If your health information is disclosed for any reason other than treatment, payment, or operation, you have the right to an accounting for each disclosure in accordance with HIPAA.

Restriction Requests: You have the right to request that the clinic place additional restrictions on uses and disclosures of your health information. We may not be able to accept your request, but if we do, we will uphold the restriction unless it is an emergency.

Communication: We must accommodate reasonable requests to receive communications of PHI from the health care provider by alternative means or at alternative locations.

Electronic Notice: If you received this notice by accessing a Web site or by e-mail, you are also entitled to have a paper copy which is available by request from the clinic or department.

Changes to this Notice

We reserve the right to change our privacy practices and terms of this Notice at any time, as permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make such changes, we will update this Notice and post the changes in the waiting room or lobby of the facility or our webpage. You may also request a copy of this Notice at any time.

Questions and Complaints

For questions regarding this Notice, please contact MSU's Privacy Officer at:

Privacy Officer
Montclair State University Academic
Affairs

1 Normal Avenue, Montclair, NJ 07043
Phone: 973/655-3459 Fax: 973/655-4159
E-mail: PrivacyOfficer@mail.montclair.edu

If you are concerned that your privacy rights may have been violated, you may contact the Privacy Officer listed above to make a complaint. **Complaints may also be made directly to the U.S. Department of Health and Human Services by following the instructions on the HHS/OCR Website at: <http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html>.**

If you choose to make a complaint with us or the U.S. Department of Health and Human Services, we will not retaliate in any way.

ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

I, _____ have received a copy of the HIPAA Privacy Notice.

PLEASE PRINT

Patient Signature Date:

HIPAA requires the Healthcare Components of Montclair State University with direct treatment relationships make a good faith effort to obtain an individual's written acknowledgment of the receipt of the Practice's privacy notice at the time of the first service delivery (except in emergencies).

PERMITTED DISCLOSURE OF INFORMATION TO FAMILY:

I authorize Montclair State University's Healthcare Components to disclose information regarding my medical condition and care to the following:

Name/Relationship

Name/Relationship

Name/Relationship

This authorization shall remain in effect unless revoked in writing.

Patient Signature Date:

REASON IF ACKNOWLEDGEMENT IS NOT SIGNED:

EMPLOYEE WITNESS:

DATE:

