CATHOLIC CHARITIES OF THE ARCHDIOCESE OF ST. PAUL AND MINNEAPOLIS

NOTICE OF PRIVACY PRACTICES

EFFECTIVE DATE OF THIS NOTICE: 4/14/03

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

PURPOSE OF THIS NOTICE

The privacy of your health information is important and our commitment is to protect health information about you. We are required by federal and state laws to protect the privacy of your health information. We must give you notice of our legal duties and privacy practices concerning your health information, including:

- We must protect information that we have created or received about your past, present, or future health condition, health care we provide to you, or payment for your health care.
- We must notify you about how we protect your health information.
- We must explain how, when and why we use or disclose your health information.
- We may only use or disclose your health information as we have described in this Notice.
- We must abide by the terms of this Notice.

We are required to abide by the terms of this Notice. We reserve the right to change the terms of this Notice and to make new Notice provisions effective for all health information that we maintain. We will post a revised Notice in our offices, make copies available to you upon request and post the revised Notice on our web site, www.ccspm.org.

USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

There are a number of purposes for which it may be necessary for us to use or disclose your health information. For some of these purposes, we are required to obtain your consent. In other instances, we may be required to obtain a more specific authorization. And in a limited number of circumstances, we are authorized by law to disclose your health information without your consent or authorization. Following is a description of these uses and disclosures.

A. Uses and Disclosures of Your Health Information for Purposes of Treatment, Payment and Health Care Operations.

- ***Health Care Treatment.*** We may use or disclose health information about you to provide and manage your health care. This may include communicating with other health care providers such as, doctors, nurses, social workers, other clinicians, professionals in training, technicians, and other persons who need the information to take care of you, and may also include using and disclosing health information about you when you need related services such as ultra sounds, lab procedures, physical exams, counseling, mental health treatment and residential care. These uses and disclosures may be made by and to persons within our organization and, in some circumstances, to people outside Catholic Charities who may be involved with your health care.
- ***Appointment Reminders and Other Contacts.*** We may use your health information to contact you with reminders about your appointments, alternative treatments you may want to consider, other of our services that may be of interest to you, and other matters. We may contact you by mail, telephone or email. For example, we may leave voice mail messages at the telephone number you provide us with, and we may respond to your email address.
- ***Payment.*** We may use or disclose your health information to bill and collect payment for the treatment and services provided to you. For example: A bill may be sent to you, or your health plan, or another third party payer. The information on, or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, supplies used, and other information about your care.
- ***Health Care Operations.*** We may use or disclose your health information inside and outside Catholic Charities to allow us to perform necessary business functions. These uses help us operate Catholic Charities and to improve

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our health care services to you. For example, we may use your health information to help us train new staff and conduct quality improvement activities. We may, also disclose your information to consultants and other business associates who help us with these activities, but not limited to, billing, computer support, transcription services, licensing, legal and accounting services, and other operational and management activities.

B. Specific Other Uses and Disclosures of Your Health Information.

- ***Minors and incapacitated Persons.*** In most circumstances, we may disclose your health care information to a parent or guardian of a minor; and to the guardian or personal representative of an incapacitated person. There are, however, limited circumstances in which a minor may choose to not have certain specific information about them shared with a parent or guardian.
- ***Emergencies/Other situations.*** We may release your health care information in a medical emergency when we cannot obtain your consent because of your condition or the nature of the emergency. Under limited circumstances, unless you notify us that you object, we may disclose limited information about you to a personal representative or another person responsible for or involved in your care, in order to notify such person about your current location or general condition.

C. Uses and Disclosures Authorized by Law.

Under certain other circumstances we are authorized by law to use or disclose your health information without obtaining a consent or authorization from you. These may include when the use or disclosure is:

- ***Required by state, federal or local law.***
- ***For public health activities.*** As permitted or required by law. For example, when reporting to public health authorities the exposure to certain communicable diseases or risks of contracting or spreading a disease or condition, births and deaths.
- ***For health oversight activities.*** For example, when disclosing health information to a state or federal health oversight agency so it can appropriately monitor the health care system. For example by conducting audits, investigations and inspections.
- ***Related to victims of abuse and neglect.***
- ***For organ donation and transplantation purposes.***
- ***For judicial and administrative proceedings.*** For example, when responding to a court order, subpoena, warrant, or similar process.
- ***For certain law enforcement purposes.*** For example, when complying with laws that require the reporting of certain types of wounds or injuries, or in some circumstances, to identify or locate a suspect, or missing person, obtain information about the victim of a crime, or information about a criminal act on our premises.
- ***To a coroner or medical examiner*** to allow them to carry out their duties.
- ***To avert a serious threat to health or safety*** of you, another person or the public.
- ***Related to specialized government functions.*** For example, to respond to military and veterans' activities or national security.
- ***Related to Workers' Compensation***.
- ***Related to correctional institutions*** and other custody situations.
- ***For certain research purposes*** under limited circumstances.

Minnesota Patient Consent for Disclosures.

For some of the disclosures of health information described above, we are required by Minnesota law to obtain a written consent from you, unless the disclosure is authorized by law.

D. Uses and Disclosures of Your Health Information that Require Your Authorization.

Other uses and disclosures of your health information not covered in this Notice will be made only with your written authorization. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any uses or disclosures made while your authorization was still in effect.

YOUR INDIVIDUAL RIGHTS

A. Right to Access and Copy Your Health Information.

With some exceptions, you have the right to inspect and request a copy of your health records, billing records and records used to make decisions about your care or services if those records include health information about you and are maintained or used by us. Your request must be made in writing, signed and dated. We may charge a reasonable fee. There are limited situations in which we may deny your request. In these situations, we will let you know why we cannot grant your request and how to request a review of our denial.

B. Right to Request an Amendment of Your Health Information.

You have the right to request that we amend your health information if you feel that records are incorrect or incomplete. If you wish to have your health information corrected or completed, your request must be made in writing, signed and dated, and

explain your reason for the amendment, and identify the record you are requesting be amended. Under limited circumstances we may deny your request. If we do so, you may file a statement of disagreement with us. You may also ask that any future disclosures of your health information include your requested amendment and our denial of your request.

C. Right to Request Restrictions on Uses and Disclosures of Your Health Information.
You have the right to request that we restrict our use or disclosure of your health information. We ask that your request be made in writing. We are not required to agree to your request for a restriction. However, if we do agree, we will comply with our agreement, unless there is an emergency or we are otherwise required to use or disclose the information.

D. Right to Request Confidential Communications.
You have the right to request that we communicate with you in a specific way or at a specific location. For example, you may request that we contact you at your work address or by email. Your request must be made in writing, signed and dated. We will make efforts to accommodate reasonable requests.

E. Right to Request and Accounting of Disclosures of Health Information.
You have the right to request an accounting of certain disclosures we make of your health information. Your request must be made in writing, signed and dated. Certain disclosures, such as those made with your consent and/or for treatment, payment or health care operations, and other disclosures exempted by law, will not be included in the accounting provided to you. Your request must state a time period, which may not be longer than six (6) years and may not include dates before April 14, 2003. The first accounting you request within a 12-month period will be free. For additional accountings, we may charge you for the costs of providing the accounting. We will notify you in advance of the cost involved.

F. Right to Receive a Copy of This Notice.
You have the right to receive a paper copy of this Notice at any time. We will make this Notice available in electronic form and post it in our web site.

To exercise any of these rights, please contact our Privacy Office listed below.

QUESTIONS OR COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact our Privacy Officer. If you are concerned that your privacy rights have been violated, you may file a complaint with our Privacy Officer. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address of the Department upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

PRIVACY OFFICER CONTACT INFORMATION

Name: Carol Hood, Catholic Charities Privacy Officer
Address: 1200 2nd Avenue South, Minneapolis, MN 55403

Phone: 612.664.8525 **Fax:** 612.664.8555 **e-mail:** Chood@CCSPM.ORG

Website: www.ccspm.org

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CATHOLIC CHARITIES OF THE ARCHDIOCES OF

ST. PAUL AND MINNEAPOLIS

ACKNOWLEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have been provided with a copy of this Notice **Of Privacy Practices**

____
Signature of Client **Date**

____
Signature of Personal Representative if Applicable **Date**
(Example) Parent, Legal Guardian, Case Manager, Health Care Agent

If Signed by Personal Representative, Relationship to Client: ________________________________

For Office Use Only

Client is a Minor, Personal Representative not Present

____
Client Name **Date**

____
Explanation

Client is not Capable of Signing at this Time

____
Client Name **Date**

____
Explanation

Client Declined to Sign Acknowledgement of Notice of Privacy Practices

____
Client Name **Date**

____
Explanation

Employee's Signature ____

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Revised Date: November 2007
Approved Date: November 11, 2007

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