

## Resolutions Hospice Houston

### 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**

#### YOUR RIGHTS

---

When it comes to your health information, you have certain rights. You have the right to:

- ❖ **Get an electronic or paper copy of your medical records**
  - You may ask to see or obtain an electronic or paper copy of your medical records and other health information we have about you. Ask us how to do this
  - We will provide a copy or a summary of your health information and may charge a reasonable, cost-based fee for doing so
- ❖ **Ask us to correct your medical records**
  - You may ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this
  - We may deny your request and will provide you a reason in writing
- ❖ **Request confidential communications**
  - You may ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address
  - We will comply with all reasonable requests
- ❖ **Ask us to limit what we use or share**
  - You may ask us **not** to use or share certain health information for treatment, payment or our operations. We may deny your request if we believe it may affect your care
  - If you pay for a service or health care item out of pocket in full, you may ask us not to share that information for the purpose of payment or our operations with your health insurer. We will comply with your request unless a law requires us to share that information
- ❖ **Get a list of those with whom we have shared your information**
  - You may request a list (accounting) of the times and to whom we have shared your health information for six (6) years prior to the date you ask.
  - We will include all the disclosures except for those about treatment, payment and healthcare operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free and may charge a reasonable, cost-based fee if you request additional lists within twelve (12) months.

- ❖ **Get a copy of this privacy notice**
  - You may ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly
- ❖ **Choose someone to act for you**
  - If you have given someone medical power of attorney or if someone is your legal guardian, that person may exercise your rights and make choices about your health information
  - We will verify the person has this authority and may act for you before we take any action
- ❖ **File a complaint if you feel your rights have been violated**
  - You may complain if you feel we have violated your right by contacting us using the information below. We will not retaliate against you for filing a complaint.
    - *Our Compliance Hotline is available 24 hours per day, 7 days per week at 1-866-987-3715 or [pennantservices.ethicspoint.com](http://pennantservices.ethicspoint.com)*
  - You may file a complaint with the U.S Department of Health and Human Services Office for Civil Rights by sending a letter to:  
**200 Independence Avenue, S.W. Washington, D.C 20201, calling 1-877-696-6775, or by visiting [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/).**

## YOUR CHOICES

---

For certain health information, you may tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

***If you are not able to tell us your preference, for example if you are unconscious, we may share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.***

- ❖ **In these cases, you have both the right and choice to tell us to:**
  - Share information with your family, close friends, or others involved in your care
  - Share information in a disaster relief situation
  - Include your information in a directory
- ❖ **In these cases we may not share your information unless you give us written permission:**
  - Marketing purposes
  - Sale of your information
  - Most psychotherapy notes
- ❖ **In the case of fundraising**
  - We may contact you for fundraising efforts, but you may tell us not to contact you again

## OUR USES AND DISCLOSURES OF YOUR INFORMATION

---

We may use or share your health information for treatment, to obtain payment, and/or to operate our business.

### ❖ **Treat you**

- We may use your health information and share it with other professionals who are treating you
  - *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

### ❖ **Run our organization**

- We may use and share your health information to run our practice, improve your care, and contact you when necessary
  - *Example: we use health information about you to manage your treatment and services.*

### ❖ **Bill for your services**

- We may use and share your health information to bill and receive payment from health plans or other entities
  - *Example: We give information about you to your health insurance plan to obtain payment for your services.*

We are allowed or required to share your information in other ways – usually in ways that contribute to public good, such as public health, safety, and research. We must meet many conditions in the law before we may share your information for these purposes. For more information visit:

[www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html)

### ❖ **Help with public health and safety issues**

- We may share health information about you for certain situations such as:
  - Preventing disease
  - Helping with product recalls
  - Reporting adverse reactions to medications
  - Reporting suspected abuse, neglect, or domestic violence
  - Preventing or reducing a serious threat to a person's health or safety

### ❖ **Do research**

- We may use or share your information for health research with your written permission

### ❖ **Comply with the law**

- We may share information about you if state or federal laws require it, including with the Department of Health and Human Services (DHHS)

- ❖ **Respond to organ and tissue donation requests**
  - We may share health information about you with organ procurement organizations or other entities engaged in the procurement, banking, or transplantation for the purpose of facilitating organ and/or tissue donation
- ❖ **Work with a medical examiner or funeral director**
  - We may share health information with coroners, medical examiners, or funeral directors as necessary to carry out their duties
- ❖ **Address workers' compensation law enforcement and other government requests**
  - We may use or share health information about you:
    - For Workers' compensation claims
    - For law enforcement purposes or with a law enforcement official
    - With health oversight agencies for activities authorized by law
    - For special government functions such as military, national security, and presidential protective services.
- ❖ **Respond to lawsuits and legal actions**
  - We may share health information about you in response to a court or administrative orders, or in response to a subpoena

## **OUR RESPONSIBILITIES**

---

- ❖ We are required to maintain the privacy and security of your protected health information
- ❖ We are required to notify you promptly in the event your information is compromised
- ❖ We must follow the duties and privacy practices described in this notice and give you a copy of it on request
- ❖ We will not use or share your information other than described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind
- ❖ For more information visit:  
[www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

### **Changes to the Terms of This Notice**

We may change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request and on our web site.

**Acknowledgment of Receipt of Notice of Privacy Practices**

My signature below acknowledges that I received the Covered Entity's Notice of Privacy Practices (with a revision date of October 1, 2019.)

Refusing to sign does not prevent the covered entity from using or disclosing health information as permitted by law.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If not patient, relationship to patient: \_\_\_\_\_

(Print Name) \_\_\_\_\_

How was Notice provided to the patient: Circle One

During Admission   In-Person after Admission   By Mail/Email   Other: \_\_\_\_\_

Please return this acknowledgement to an agency employee, or deliver to:

**Resolutions Hospice Houston**  
**Attention: HIPAA Liaison**  
**12600 N Featherwood Drive. Ste. 108**  
**Houston, TX, 77034**  
**832-588-6083**

---

**[FOR AGENCY USE ONLY]**

If acknowledgement was not obtained, please complete the following:

Patient's Name: \_\_\_\_\_

Date of attempt to obtain acknowledgment: \_\_\_\_\_

Reason acknowledgment was not obtained:

- Patient/family member received notice but refused to sign acknowledgment
- Emergency treatment situation
- Patient was incapacitated and no family member was present
- Other (please describe): \_\_\_\_\_

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Communication Request Form

Patient Name: \_\_\_\_\_ Patient ID: \_\_\_\_\_

- A. **FAMILY AND FRIENDS:** It is the policy of this agency not to release confidential medical information regarding your treatment to family members or friends, except for:
- a. parent/legal guardian
  - b. other persons authorized by the patient
  - c. as we may reasonably infer from the circumstances (for example, if a family member or friend is present while we are providing care, we will assume, unless you object, that the person is entitled to receive information regarding your treatment)
  - d. in emergency situations, or
  - e. as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

If you anticipate you will need or want your medical information to be provided to family members, friends, or caregivers, please indicate below, so we may best serve you. By signing below, you authorize the following persons to receive information as requested, regarding your care and treatment. Updates to this form must be made in person.

Name	Relationship	Phone
------	--------------	-------

Name	Relationship	Phone
------	--------------	-------

Name	Relationship	Phone
------	--------------	-------

Are there any individuals (family/friends) that you do NOT wish us to communicate with regarding your medical information?

\_\_\_\_\_

\_\_\_\_\_

- B. **ALTERNATIVE COMMUNICATION:** I wish to be contacted in the following manner. (check all that apply)

Home Phone _____	Cell Phone _____
------------------	------------------

___ Okay to leave message with details	___ Okay to leave message with details
--	--

___ Leave a call back number only	___ Leave a call back number only
-----------------------------------	-----------------------------------

X _____	Relationship	Date
Patient/Responsible Party Signature		