

# UNIVERSITY PHYSICIANS OF BROOKLYN

## POLICY AND PROCEDURE

**Subject:** NOTICE OF PRIVACY PRACTICES

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No. HIPAA-16

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**Original Issue Date:** \_\_\_\_\_

**Supersedes:** \_\_\_\_\_

**Effective Date:** 04/2017

**TJC Standards:** RI.01.01.01: The hospital respects, protects, and promotes patient rights.  
RI.01.01.03: The hospital respects the patient's right to receive information in a manner he or she understands.

**Issued by:** **Regulatory Affairs**

### I. PURPOSE

To ensure that University Physicians of Brooklyn patients receive adequate notice of the uses and disclosures of protected health information (PHI) made by UPB, their individual rights and UPB's legal duties with respect to PHI to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its accompanying regulations.

### II. POLICY

**A. Joint Notice-**The NPP applies to all of the entities participating in UPB organized healthcare arrangement (See policy on Covered Entity Designation).

1. The notice must describe the class of entities to which it applies, including the classes of service delivery sites.
2. The notice must state that these entities will share PHI with each other, as necessary, to carry out treatment, payment and healthcare operations related to the organized healthcare arrangement.
3. The provision of the NPP by any one of the participating entities will satisfy the provision requirement for all the remaining entities.

**B. Exception-** An inmate does not have the right to receive a NPP.

## NOTICE OF PRIVACY PRACTICES

**C. Documentation-** The following documentation must be retained:

1. Copies of the NPP issued;
2. Written acknowledgements of receipt; and
3. Documentation of good faith efforts to obtain acknowledgements.

### III. DEFINITION(s)

None

### IV. RESPONSIBILITIES

It is the responsibility of all medical staff members and hospital staff members to comply with this policy. Medical staff members include physicians as well as allied health professionals. Hospital staff members include all employees, medical or other students, trainees, residents, interns, volunteers, consultants, contractors and subcontractors at the hospital.

### V. PROCEDURE/GUIDELINES

#### A. Provision of NPP

1. Registration staff must provide the NPP to the patient on the date of the first service delivery.
  - a. The NPP should be available in all registration areas for patients.
  - b. The NPP must be posted in all Admitting/ registration areas, outpatient suites and patient care floors.
  - c. The NPP is available in the languages most prevalent to SUNY Downstate's patient population and are posted at [www.downstate.edu/policy/patient.html](http://www.downstate.edu/policy/patient.html). For other languages, the patient should be referred to Patient Relations for interpreting services.
  - d. The NPP is available on SUNY Downstate's web-site at the URL noted above.
  - e. If the first service is delivered to a patient electronically or via telephone, the notice must be automatically provided electronically.
    - i. If an email transmission failed, a paper copy must be sent to the patient and the reason for the delay in the notice provision should be documented;
    - ii. A patient who received an electronic notice can always obtain a paper copy upon request.
  - f. Regardless of whether services are provided on physical premises or electronically, the NPP may be provided via email, if the patient agrees.
  - g. In emergency situations, the NPP should be provided as soon as reasonably practicable after the emergency treatment.
2. A good faith effort must be made to obtain the patient's written acknowledgement of receipt of the NPP.
  - a. If an acknowledgement is not obtained, the responsible staff member must document the efforts made and the reason why the acknowledgement was not obtained on the HIPAA Privacy Form.
  - b. This information should be placed in the patient's medical record and entered into the Eagle system.

#### B. Revisions to the NPP

NOTICE OF PRIVACY PRACTICES

1. The NPP must be promptly revised whenever there is a material change to the following:
  - a. Uses & disclosures;
  - b. Patient rights with respect to PHI;
  - c. UHB legal duties with respect to PHI; or
  - d. Other privacy practices stated in the NPP.
2. The revised NPP must be made available as of the effective date of the document.
3. The NPP must be made available in all of the applicable areas for distribution to new patients. Recurring patients will only be given the revised NPP upon request.

**VI. ATTACHMENTS**

Notice of Privacy Practices, HIPAA Privacy Form

**VII. REFERENCES**

Standards for Privacy of Individually Identifiable Health Information- 45  
CFR Parts 160 and 164; 164.520  
Joint commission standards

Date Reviewed	Revision Required (Circle One)		Responsible Staff Name and Title
9/2013	(Yes)	No	Shoshana Milstein, AVP, Compliance & Audit
9/2016	(Yes)	No	Shoshana Milstein, AVP, Compliance & Audit
12/2016	Yes	(No)	Shoshana Milstein, AVP, Compliance & Audit



## **NOTICE OF PRIVACY PRACTICES**

Effective Date: September 23, 2013

**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.**

We are required by law to protect the privacy of health information that may reveal your identity, and to provide you with a copy of this notice which describes our legal duties and the health information privacy practices of University Physicians of Brooklyn, its medical staff, and affiliated health care providers that jointly provide health care services with University Physicians of Brooklyn. A copy of our current notice will always be posted in our registration areas. You will also be able to obtain your own copies by accessing our website at "[www.downstate.edu](http://www.downstate.edu)", calling the Admitting Department or asking for one at the time of your next visit. You may request a paper copy of this notice at any time, even if you have previously agreed to receive this notice electronically.

*If you have any questions about this notice or would like further information, please contact a Patient Relations representative. University Physicians of Brooklyn Patient Relations Department can be reached at 718-270-8105.*

### **WHO WILL FOLLOW THIS NOTICE?**

University Physicians of Brooklyn provides health care to patients jointly with physicians and other health care professionals and organizations. The privacy practices described in this notice will be followed by:

1. All employees, medical staff, trainees, students or volunteers at:
  - a. University Physicians of Brooklyn and all its support services;
  - b. University Physicians of Brooklyn, Inc. (UPB) providing care at SUNY Downstate Medical Center;
  - c. SUNY Research Foundation.
2. Any business associates of University Physicians of Brooklyn (which are described further below).

### **PERMISSIONS DESCRIBED IN THIS NOTICE**

This notice will explain the different types of permission we will obtain from you before we use or disclose your health information for a variety of purposes. The two types of permissions referred to in this notice are:

- An "opportunity to object," which we must provide to you before we may use or disclose your health information for certain purposes.
- A "written authorization," which will provide you with detailed information about the persons who may receive your health information and the specific purposes for which your health information may be used or disclosed. We are only permitted to use and disclose your health information described on the written authorization in ways that are explained on the written authorization form you have signed. A written authorization will have an expiration date.

## IMPORTANT SUMMARY INFORMATION

**Requirement for Written Authorization.** Most uses and disclosures of psychotherapy notes, uses and disclosures of your health information for marketing purposes and disclosures that involve a sale of your health information will require your written authorization prior to the use or disclosure. In addition, any use or disclosure of your health information that is not described in this notice will only be made with your written authorization. You may also initiate the transfer of your records to another person by completing a written authorization form. If you provide us with written authorization, you may revoke that written authorization at any time, except to the extent that we have already relied upon it. To revoke a written authorization, please call the Health Information Management Department at 718-270-1845 who will provide you with the appropriate forms.

**Exceptions to Written Authorization Requirement.** There are some situations when we do not need your written authorization before using your health information or sharing it with others. They are:

- **Exception for Treatment, Payment, and Business Operations.** We may use and disclose your health information to treat your condition, collect payment for that treatment, or run our business operations. In some cases, we also may disclose your health information to another health care provider or payor for its payment activities and certain of its business operations. For more information, see page 4 of this notice.
- **Exception for Patient Directory and Disclosure to Family and Friends Involved in Your Care.** We will ask you whether you have any objection to including information about you in our Facility Directory or sharing information about your health with your friends and family involved in your care. For more information, see page 5 of this notice.
- **Exception in Emergencies or Public Need.** We may use or disclose your health information in an emergency or for important public needs. For example, we may share your information with public health officials at the New York State or City health departments who are authorized to investigate and control the spread of diseases. For more examples, see pages 5-7 of this notice.
- **Exception if Information is Completely or Partially De-Identified.** We may use or disclose your health information if we have removed any information that might identify you so that the health information is “completely de-identified.” We may also use and disclose “partially de-identified” information if the person who will receive the information agrees in writing to protect the privacy of the information. For more information, please see page 7 of this notice.

**How to Access Your Health Information.** You generally have the right to inspect and copy your health information. For more information, please see pages 7- 8 of this notice.

**How to Correct Your Health Information.** You have the right to request that we amend your health information if you believe it is inaccurate or incomplete. For more information, please see page 8 of this notice.

**How to Identify Others who have Received Your Health Information.** You have the right to receive an “accounting of disclosures,” which identifies certain persons or organizations to whom we have disclosed your health information in accordance with the protections described in this Notice of Privacy Practices. Many routine disclosures we make will not be included in this accounting, but the accounting will identify many non-routine disclosures of your information. For more information, please see pages 8- 9 of this notice.

**How to Request Additional Privacy Protections.** You have the right to request further restrictions on the way we use your health information or share it with others. We are not required to agree to the restriction you request, but if we do, we will be bound by our agreement. However, if you request to restrict disclosure of your health information to a payor for payment or health care operations and the disclosure pertains to a health care item or service you (or another person on your behalf) paid out of pocket in full at the time of your request, we are required under law to agree to your restriction. For more information, please see page 9 of this notice.

**How to Request More Confidential Communications.** You have the right to request that we contact you in a way that is more confidential for you, such as at home instead of at work. We will try to accommodate all reasonable requests. For more information, please see page 9 of this notice.

**How Someone May Act on Your Behalf.** You have the right to name a personal representative who may act on your behalf to control the privacy of your health information. Parents and guardians will generally have the right to control the privacy of health information about minors unless the minors are permitted by law to act on their own behalf.

**How to Learn About Special Protections for HIV, Alcohol and Substance Abuse, Mental Health and Genetic Information.** Special privacy protections apply to HIV-related information, alcohol and substance abuse treatment information, mental health information, and genetic information. Some parts of this general Notice of Privacy Practices may not apply to these types of information. If your treatment involves this information, you will be provided with separate notices explaining how the information will be protected. To request copies of these other notices now, please contact the Admitting Department at 718-270-2862.

**How to Obtain a Copy of Revised Notice.** We may change our privacy practices from time to time. If we do, we will revise this notice so you will have an accurate summary of our practices. The revised notice will apply to all of your health information. We will post any revised notice in our registration areas. We will also provide you with your own copy of the revised notice upon request. The effective date of the notice will always be noted in the top right corner of the first page. We are required to abide by the terms of the notice that is currently in effect.

**How You will be Notified of a Breach.** We take the protection of your health information very seriously. However, in the unfortunate event that there is a breach of your unsecured health information, you have a right to be informed of the breach. We will send you a written notification regarding the details of the breach and if we are unsuccessful in reaching you, we will make every effort to contact you via alternate methods.

**How to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. *No one will retaliate or take action against you for filing a complaint.*

To file a complaint with us, please contact a Patient Relations representative at 718-270-8105. You can also contact SUNY Downstate Medical Center's Compliance Line at **877-349-SUNY (7869)** or make a web report by clicking the "Compliance Line" on the bottom of SUNY Downstate Medical Center's website [www.downstate.edu](http://www.downstate.edu).

To file a complaint with the Department of Health and Human Services, you can write or call:

Office for Civil Rights  
U.S. Department of Health & Human Services  
26 Federal Plaza - Suite 3313  
New York, NY 10278

Telephone number: (212) 264-3313  
TDD: (212) 264-2355  
Fax number: (212) 264-3039

## NOTICE OF PRIVACY PRACTICES- DETAILS

We are committed to protecting the privacy of information we gather about you while providing health-related services. Some examples of protected health information are:

- information indicating that you are our patient or receiving treatment or other health-related services from us;
- information about your health condition (such as a disease you may have);
- information about health care products or services you have received or may receive in the future (such as an operation); or
- information about your health care benefits under an insurance plan (such as whether a prescription is covered);

*when combined with:*

- demographic information (such as your name, address or insurance status);
- unique numbers that may identify you (such as your social security number, your phone number or your driver's license number); and
- other types of information that may identify who you are.

### **III. HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION**

#### **1. Treatment, Payment and Business Operations**

*Prior to receiving services from University Physicians of Brooklyn, you will be asked to sign a statement so that we may use your health information or share it with others in order to treat your condition, obtain payment for that treatment and run our business operations. In some cases, we may also disclose your health information for payment activities and certain business operations of another health care provider or payor. Below are further examples of how your information may be used and disclosed for these purposes.*

**Treatment.** We may share your health information with doctors or nurses at SUNY Downstate Medical Center who are involved in taking care of you and they may in turn use that information to diagnose or treat you. For example, our doctors may share your health information with another doctor inside our hospital or with a doctor at another hospital to determine how to diagnose or treat you. Your doctor may also share your health information with another doctor to whom you have been referred for further health care.

**Payment.** We may use your health information or share it with others so that we may obtain payment for your health care services. For example, we may share information about you with your health insurance company in order to obtain reimbursement after we have treated you or to determine whether it will cover your treatment. We might also need to inform your health insurance company about your health condition in order to obtain pre-approval for your treatment, such as admitting you to the hospital for a particular type of surgery. Finally, we may share your information with other health care providers and payors for their payment activities.

**Business Operations.** We may use your health information or share it with others in order to conduct our business operations. For example, we may use your health information to evaluate the performance of our staff in caring for you or to educate our staff on how to improve the care they provide for you. Finally, we may share your health information with other health care providers and payors for certain of their business operations if the information is related to a relationship the provider or payor currently has or previously had with you and if the provider or payor is required by federal law to protect the privacy of your health information.

**Fundraising.** To support our business operations, we may use demographic information about you, including information about your age, gender and date of birth, where you live or work, the dates that you received treatment, your health insurance status, the department or office where you received treatment, the name of the physician that treated you and general outcome information (such as a positive or negative result of treatment) in order to contact you to raise money to help us operate. We may also share this information with a charitable foundation that will contact you to raise money on our behalf. You have a right to opt out of receiving fundraising communications from us. To do so, please contact the Patient Relations Department at 718-270-8105 who will provide you with an appropriate request form. In addition, you will also have the opportunity to opt out of receiving any further fundraising communications with any solicitation letter you receive from us.

**Business Associates.** We may disclose your health information to contractors, agents and other business associates who need the information in order to assist us with obtaining payment or carrying out our business operations. For example, we may share your health information with a billing company that helps us to obtain payment from your insurance company. Another example is that we may share your health information with an accounting firm or law firm that provides professional advice to us about how to improve our health care services and comply with the law. If we do disclose your health information to a business associate, we will have a written contract to ensure that our business associate also protects the privacy of your health information.

**Healthcare Students & Trainees.** SUNY Downstate Medical Center is an academic center that provides clinical training and internships to healthcare students and trainees. As such, we may share your information with them, provided that they abide by our policies in protecting your privacy.

## **2. Patient Directory/Family and Friends**

*We may use and disclose your health information in our Facility Directory or share it with family and friends involved in your care without your written authorization. You will always be given an opportunity to object upon registration. In medical emergencies, we will discuss your preferences with you as soon as the emergency is over. You can modify or terminate your objection at any time. We will follow your wishes unless we are required by law to do otherwise.*

**Facility Directory.** If you do not object, we will include your name, your location in our facility, your general condition (*e.g.*, fair, stable, critical, etc.) and your religious affiliation in our Facility Directory while you are a patient in the hospital or one of the facilities listed at the beginning of this notice. This directory information, except for your religious affiliation, may be released to people who ask for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or rabbi, even if he or she doesn't ask for you by name.

**Family and Friends Involved in Your Care.** Upon registration, you will be given the opportunity to identify family members, relatives or close personal friends that we may share your health information with who are involved in your care or payment for that care. We may also notify a family member, personal representative or another person responsible for your care about your location and general condition here at the hospital or about the unfortunate event of your death. In some cases, we may need to share your information with a disaster relief organization that will help us notify these persons.

## **3. Emergencies or Public Need**

*We may use your health information and share it with others in order to treat you in an emergency or to meet important public needs. We will not be required to obtain your general written consent or written authorization before using or disclosing your information for these reasons. We will, however, obtain your written authorization for, or provide you with an opportunity to object to, the use and disclosure of your health information in these situations when state law specifically requires that we do so.*

**Emergencies.** We may use or disclose your health information if you need emergency treatment or if we are required by law to treat you but are unable to obtain your general written consent. If this happens, we will try to obtain your general written consent as soon as we reasonably can after we treat you.

**Communication Barriers.** We may use and disclose your health information if we are unable to obtain your general written consent because of substantial communication barriers, and we believe you would want us to treat you if we could communicate with you.

**As Required by Law.** We may use or disclose your health information if we are required by law to do so. We also will notify you of these uses and disclosures if notice is required by law.

**Public Health Activities.** We may disclose your health information to authorized public health officials (or a foreign government agency collaborating with such officials) so they may carry out their public health activities. For example, we may share your health information with government officials that are responsible for controlling disease, injury or disability or to report births and deaths. We may also disclose your health information to a person who may have been exposed to a communicable disease or be at risk for contracting or spreading the disease if a law permits us to do so. And finally, we may release some health information about you to your employer if your



employer hires us to provide you with a physical exam and we discover that you have a work-related injury or disease that your employer must know about in order to comply with employment laws.

**Victims of Abuse, Neglect or Domestic Violence.** We may release your health information to a public health authority that is authorized to receive reports of abuse, neglect or domestic violence. For example, we may report your information to government officials if we reasonably believe that you have been a victim of such abuse, neglect or domestic violence. We will make every effort to obtain your permission before releasing this information, but in some cases we may be required or authorized to act without your permission.

**Health Oversight Activities.** We may release your health information to government agencies authorized to conduct audits, investigations, and inspections of our facility. These government agencies monitor the operation of the health care system, government benefit programs such as Medicare and Medicaid and compliance with government regulatory programs and civil rights laws.

**Product Monitoring, Repair and Recall.** We may disclose your health information to a person or company that is regulated by the Food and Drug Administration for the purpose of: (1) reporting or tracking product defects or problems; (2) repairing, replacing, or recalling defective or dangerous products; or (3) monitoring the performance of a product after it has been approved for use by the general public.

**Lawsuits and Disputes.** We may disclose your health information if we are ordered to do so by a court or administrative tribunal that is handling a lawsuit or other dispute.

**Law Enforcement.** We may disclose your health information to law enforcement officials for the following reasons:

- To comply with court orders or laws that we are required to follow;
- To assist law enforcement officers with identifying or locating a suspect, fugitive, witness, or missing person;
- If you have been the victim of a crime and we determine that: (1) we have been unable to obtain your general written consent because of an emergency or your incapacity; (2) law enforcement officials need this information immediately to carry out their law enforcement duties; and (3) in our professional judgment disclosure to these officers is in your best interests;
- If we suspect that your death resulted from criminal conduct;
- If necessary to report a crime that occurred on our property; or
- If necessary to report a crime discovered during an offsite medical emergency (for example, by emergency medical technicians at the scene of a crime).

**To Avert a Serious and Imminent Threat to Health or Safety.** We may use your health information or share it with others when necessary to prevent a serious and imminent threat to your health or safety or the health or safety of another person or the public. In such cases, we will only share your information with someone able to help prevent the threat. We may also disclose your health information to law enforcement officers if you tell us that you participated in a violent crime that may have caused serious physical harm to another person (unless you admitted that fact while in counseling) or if we determine that you escaped from lawful custody (such as a prison or mental health institution).

**National Security and Intelligence Activities or Protective Services.** We may disclose your health information to authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President or other important officials.

**Military and Veterans.** If you are in the Armed Forces, we may disclose health information about you to appropriate military command authorities for activities they deem necessary to carry out their military mission. We may also release health information about foreign military personnel to the appropriate foreign military authority.

**Inmates and Correctional Institutions.** If you are an inmate or you are detained by a law enforcement officer, we may disclose your health information to the prison or law enforcement officers, if necessary, to provide you with health care or to maintain safety, security and good order at the place where you are confined. This includes sharing

information that is necessary to protect the health and safety of other inmates or persons involved in supervising or transporting inmates.

**Workers' Compensation.** We may disclose your health information for workers' compensation or similar programs that provide benefits for work-related injuries.

**Coroners, Medical Examiners and Funeral Directors.** In the unfortunate event of your death, we may use and disclose your health information to a coroner or medical examiner. This may be necessary, for example, to determine the cause of death. We may also release this information to funeral directors, as necessary, to carry out their duties.

**Organ and Tissue Donation.** In the unfortunate event of your death, we may disclose your health information to organizations that procure or store organs, eyes or other tissues so that these organizations may investigate whether donation or transplantation is possible under applicable laws.

**Research.** In most cases, we will ask for your written authorization before using your health information or sharing it with others in order to conduct research. However, under some circumstances, we may use and disclose your health information without your written authorization if we obtain approval through a special process to ensure that research without your written authorization poses minimal risk to your privacy. Under no circumstances, however, would we allow researchers to use your name or identity publicly. We may also release your health information without your written authorization to people who are preparing a future research project, so long as any information identifying you does not leave our facility. In the unfortunate event of your death, we may share your health information with people who are conducting research using the information of deceased persons, as long as they agree not to remove from our facility any information that identifies you. After 50 years of death, the health information is no longer covered under the protections outlined in this notice.

#### **4. Completely De-identified or Partially De-identified Information.**

We may use and disclose your health information if we have removed any information that has the potential to identify you so that the health information is "completely de-identified." We may also use and disclose "partially de-identified" health information about you if the person who will receive the information signs an agreement to protect the privacy of the information as required by federal and state law. Partially de-identified health information will *not* contain any information that would directly identify you (such as your name, street address, social security number, phone number, fax number, electronic mail address, website address, or license number).

#### **5. Incidental Disclosures**

While we will take reasonable steps to safeguard the privacy of your health information, certain disclosures of your health information may occur during, or as an unavoidable result of, our otherwise permissible uses or disclosures of your health information. For example, during the course of a treatment session, other patients in the treatment area may see or overhear discussion of your health information.

### **IV. YOUR RIGHTS TO ACCESS AND CONTROL YOUR HEALTH INFORMATION**

*We want you to know that you have the following rights to access and control your health information. These rights are important because they will help you make sure that the health information we have about you is accurate. They may also help you control the way we use your information and share it with others, or the way we communicate with you about your medical matters.*

#### **1. Right to Inspect and Copy Records**

You have the right to inspect and obtain a copy of any of your health information that may be used to make decisions about you and your treatment for as long as we maintain this information in our records. This includes medical and billing records. To inspect or obtain a copy of your health information, please contact the Health Information Management Department at 718-270-1845 who will provide you with an appropriate request form. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies we use to fulfill your request. The standard fee is \$0.75 per page and must generally be paid before or at the time we give the copies to you.

We will respond to your request for inspection of records within 10 days. We ordinarily will respond to requests for copies within 30 days. In the event that we need additional time to respond to a request for copies, we will notify you in writing within the time frame above to explain the reason for the delay and when you can expect to have a final answer to your request. However, we will always respond to your request for copies within 60 days.

Under certain very limited circumstances, we may deny your request to inspect or obtain a copy of your information. If we do, we will provide you with a summary of the information instead. We will also provide a written notice that explains our reasons for providing only a summary, a complete description of your rights to have that decision reviewed and how you can exercise those rights. The notice will also include information on how to file a complaint about these issues with us or with the Secretary of the Department of Health and Human Services. If we have reason to deny only part of your request, we will provide complete access to the remaining parts after excluding the information we cannot let you inspect or copy.

## **2. Right to Amend Records**

If you believe that 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 for as long as the information is kept in our records. To request an amendment, please contact the Health Information Management Department at 718-270-1845 who will provide you with an appropriate request form. On the request form, you must include the reasons why you think we should make the amendment. Ordinarily, we will respond to your request within 60 days. If we need additional time to respond, we will notify you in writing within 60 days to explain the reason for the delay and when you can expect to have a final answer to your request.

If we deny part or all of your request, we will provide a written notice that explains our reasons for doing so. You will have the right to have certain information related to your requested amendment included in your records. For example, if you disagree with our decision, you will have an opportunity to submit a statement explaining your disagreement which we will include in your records. We will also include information on how to file a complaint with us or with the Secretary of the Department of Health and Human Services. These procedures will be explained in more detail in any written denial notice we send you.

## **3. Right to an Accounting of Disclosures**

You have a right to request an “accounting of disclosures” which identifies certain other persons or organizations to whom we have disclosed your health information in accordance with applicable law and the protections afforded in this Notice of Privacy Practices. An accounting of disclosures does not describe the ways that your health information has been shared within and between the hospital and the facilities listed at the beginning of this notice, as long as all other protections described in this Notice of Privacy Practices have been followed (such as obtaining the required approvals before sharing your health information with our doctors for research purposes).

An accounting of disclosures also does not include information about the following disclosures:

- Disclosures we made to you or your personal representative;
- Disclosures we made pursuant to your written authorization;
- Disclosures we made for treatment, payment or business operations;
- Disclosures made from the patient directory;
- Disclosures made to your friends and family involved in your care or payment for your care;
- Disclosures that were incidental to permissible uses and disclosures of your health information (for example, when information is overheard by another patient passing by);
- Disclosures for purposes of research, public health or our business operations of limited portions of your health information that do not directly identify you;
- Disclosures made to federal officials for national security and intelligence activities;
- Disclosures about inmates to correctional institutions or law enforcement officers;
- Disclosures made before April 14, 2003 (the effective date of the HIPAA Privacy Rule).

To request an accounting of disclosures, please contact the Health Information Management Department at 718-270-1845 who will provide you with an appropriate request form. On the request form, you must state a time period within the past six years for the disclosures you want us to include. For example, you may request a list of the disclosures that we made between January 1, 2012 and January 1, 2013. You have a right to receive one accounting within every 12 month period for free. However, we may charge you for the cost of providing any additional

accounting in that same 12 month period. We will always notify you of any cost involved so that you may choose to withdraw or modify your request before any costs are incurred.

Ordinarily we will respond to your request for an accounting within 60 days. If we need additional time to prepare the accounting you have requested, we will notify you in writing about the reason for the delay and the date when you can expect to receive the accounting. In rare cases, we may have to delay providing you with the accounting without notifying you because a law enforcement official or government agency has asked us to do so.

#### **4. Right to Request Additional Privacy Protections**

You have the right to request that we further restrict the way we use and disclose your health information to treat your condition, collect payment for that treatment or run our business operations. You may also request that we limit how we disclose information about you to family or friends involved in your care. For example, you could request that we not disclose information about a surgery you had. You will be given the opportunity to request a restriction upon registration. You may also contact the Patient Relations Department at 718-270-8105 who will provide you with an appropriate request form. On the request form, you must include (1) what information you want to limit; (2) whether you want to limit how we use the information, how we share it with others, or both; and (3) to whom you want the limits to apply.

We are not required to agree to your request for a restriction and in some cases the restriction you request may not be permitted under law. *If we do agree, we will be bound by our agreement unless the information is needed to provide you with emergency treatment or comply with the law.* However, if you request to restrict disclosure of your health information to a payor for payment or health care operations and the disclosure pertains to a health care item or service you (or another person on your behalf) paid out of pocket in full at the time of your request, we are required under law to agree to your restriction. Once we have agreed to a restriction, you have the right to revoke the restriction at any time. Under some circumstances, we will also have the right to revoke the restriction as long as we notify you before doing so; in other cases, we will need your permission before we can revoke the restriction.

#### **5. Right to Request Confidential Communications**

You have the right to request that we communicate with you about your medical matters in a more confidential way by requesting that we communicate with you by alternative means or at alternative locations. For example, you may ask that we contact you at home instead of at work. You will be given the opportunity to request a confidential communications upon registration. You may also contact the Patient Relations Department at 718-270-8105 who will provide you with an appropriate request form. On the request form, you must specify how or where you wish to be contacted and how payment for your health care will be handled if we communicate with you through this alternative method or location. *We will not ask you the reason for your request and will try to accommodate all reasonable requests.*

Name: \_\_\_\_\_

MR#: \_\_\_\_\_  
*(Please affix label or print)*

N.S.: \_\_\_\_\_

Service/Dr: \_\_\_\_\_

## HIPAA PRIVACY FORM NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

*This form will be provided to you upon registration. In the case of a medical emergency, this form will be provided to you as soon as reasonably practicable after your emergency treatment is over.*

Name of Patient/ Personal Representative: \_\_\_\_\_

You are entitled to our **Notice of Privacy Practices** describing how your health information can be used and disclosed by University Physicians of Brooklyn Health Science Center at Brooklyn and how you can obtain access to and control this information.

Our Notice of Privacy Practices will be provided to you upon registration or admission. It is also posted in our registration areas and is available on our website at [www.downstate.edu](http://www.downstate.edu).

We have additional Notices of Privacy Practices for HIV, mental health and alcohol & substance abuse information. You can request a copy of these notices at any time.

Patient/Surrogate Name (Print)	Signature	Date	Time
Relationship to Patient			

**For UHB Employee Use Only:**

\_\_\_\_\_ Patient would not acknowledge receipt of Notice of Privacy Practices. Documentation of good faith effort to obtain acknowledgement and reason not obtained:

\_\_\_\_\_

\_\_\_\_\_

