El Dorado County
Risk Management
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Your Information. Your Rights.
Our Responsibilities.

This notice describes how health and personal identifying 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 or personal identifying information , you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records that we create	• You can ask to see or get a copy of your health and claims 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 and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct health and claims records that we create	• You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. • We may say “no” to your request, but we’ll tell you why in writing within 60 days.
Request confidential communications	• You can 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 consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.
Ask us to limit what we use or share	• You can ask us not to use or share certain health information for treatment, payment, or our operations. • We are not required to agree to your request, and we may say “no” if it would affect your health care, eligibility for benefits, safety or violates other California or federal law.
Get a list of those with whom we’ve shared information	• You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures, except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free, but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can 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 legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can 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 visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**. • We will not retaliate against you for filing a complaint.

Your Choices

For certain health and personal identifying information, you can 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.

In these cases, you have both the right and choice to tell us to:	• Share information with your family. Close friends, or others involves in payment for your care • Share information in a disaster relief situation • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and 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 we never share your information unless you give us written permissions:	• Marketing purposes. • Sale of your information. • Exchange concerning substance abuse services, benefits receipt or behavioral health services except as authorized by law.

Our Primary Uses and Disclosures

How do we typically use or share your health or personal identifying information? We typically use or share your information in the following ways.

Help manage the health care treatment you receive or coordinate the benefits and services you voluntarily apply for	• We can use your health information and share it with professionals who are treating you. ***Example:*** *A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.* • Collection of personal identifying information is required to deliver the specific services you request. • Mandatory information is identified on all application forms
Run our organization	• We can use and disclose your information to run our organization and contact you when necessary. • We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans. ***Example:*** *We use health information about you to develop better services for you.*
Pay for your health services	• We can use and disclose your health information as we pay for your health services. ***Example:*** *We share information about you with your dental plan to coordinate payment for your dental work.*
Administer your plan	• We may disclose your health information to your health plan sponsor for plan administration. ***Example:*** *Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

Our Secondary Uses and Disclosures

How else can we use or share your health information? We are allowed or required share your information in other ways - usually in ways that contribute to the public good, such as public health and research. We often share demographic information such as number of people in El Dorado County with certain disease or age, but in those instances the information we share is not identifiable. We have to meet many conditions in the law before we can share your information for these purposes, for more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues	• We can 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 anyone's health or safety

Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Address workers' compensation, law enforcement, and other government request	• We can 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 can share health information about you in response to a court administrative order, or in response to a subpoena.
Apply for full scope Medi-Cal	• If you are applying for full scope Medi-Cal benefits, we must check your immigration status with the U.S. Citizenship and Immigration Services (USCIS).
Administer our programs	• We can share your information with our contractors and agents who help us administer our programs.
Comply with special laws	• There are special laws that protect some types of health information such as mental health services, treatment for substance use disorders, and HIV/AIDS testing and treatment. We will obey these laws when they are stricter then this notice.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as 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 see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice

We can 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, on our website, and we will mail a copy to you.

Effective Date:

This Notice of Privacy Practices Applies to the Following Organizations

This notice applies to all El Dorado County programs, including Medi-Cal.

Patient Name: _____

By signing this form, you agree that you received a copy of the *Notice of Privacy Practices* of El Dorado County. Our *Notice of Privacy Practices* tells you how we may use and disclose your protected health information. We ask that you read all of it.

I received a copy of the *Notice of Privacy Practices* of El Dorado County.

Date: _____ **Time:** _____ a.m./p.m. **Signature:**_____
Patient or Legal Representative

If signed by someone other than patient, indicate relationship: _____

Print name: _____
Legal Representative

Office Use Only:

INABILITY TO OBTAIN ACKNOWLEDGMENT

Description of good faith effort and reason why Acknowledgment was not obtained:

Patient Name: _____

Good Faith Effort:

☐ Provided copy of notice to patient or legal representative

☐ Presented Acknowledgement to patient or legal representative for signature

☐ Other: _____

Reason(s) why the Acknowledgment was not obtained:

☐ Patient or legal representative refused to sign

☐ Other: _____

Provider Representative Signature: _____

Provider Representative Name: _____

Date: _____ **Time:** _____ a.m./p.m.