

## HIPAA NOTICE OF PATIENT PRIVACY PRACTICES

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### **THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

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**\*Advocates for Science and Math Education/LSUHSC SBHC\* and the New Orleans Health Department (NOHD)** understands that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and testing services you receive. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated or maintained by Advocates for Science and Math Education/LSUHSC SBHC

This notice will tell you how we may use or disclose information about you. Not all situations will be described. We are required to give you a notice of our privacy practices for the information we collect and keep about you. We are required to follow the terms of the notice currently in effect.

We are required by law to:

- Use our best efforts to keep medical information that identifies you private;
- Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice that is currently in effect.

#### ***How We May Use and Disclose Medical Information About You.***

The following categories describe different ways that we use and disclose medical information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- **Treatment.** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to the various practitioners within **Advocates for Science and Math Education/LSUHSC SBHC and NOHD** to coordinate the different types of care and things you need. We also may disclose medical information about you to people outside , who may be involved in your care such as family members.
- **Health Care Operations.** We may use and disclose medical information about you for **Advocates for Science and Math/LSUHSC SBHC** Clinic operations. These uses and disclosures are necessary to run the clinic and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our practitioners and/or staff in caring for you

**Insurance/Reimbursement.** We may use and disclose medical information about you to obtain payment from your insurance company or other health plan for health care provided to you.

- **As Required By Law.** We will disclose medical information about you when required to do so by federal, state or local law.
- **To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.
- **Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law to inspect or investigate health care providers.
- **Law Enforcement.** We may release medical information if asked to do so by a law enforcement official: in response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement.

***Your Rights Regarding Medical Information About You***

You have the following rights regarding medical information we maintain about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy some of the medical information that may be used to make decisions about your care. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.
- **Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may ask to amend the information to your records. You must make the request in writing and provide a reason for your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
  - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
  - Is not part of the medical information kept by or for the clinic/school;
  - Is not part of the information which you would be permitted to inspect and copy; or Is accurate and complete.

- **Right to Disclosures.** You have the right to request a list of disclosures. This is a list of the disclosures we have made of medical information about you. You must make the request in writing and must state a time period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. ***We are not required to agree to your request.*** If we do agree, we will comply with your request.
- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.
- **Electronic Communication.** If you request information to be transmitted electronically, please be advised that your private information may not be protected. We cannot guarantee that any information you receive from us will be received through a secure network. We will take every step necessary on our end to protect your privacy.

#### ***Changes to This Notice***

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. In addition, each time you register, you may obtain a copy of the current notice in effect.

#### ***Complaints***

If you believe your privacy rights have been violated, you may file a complaint with the **Advocates for Science and Math Education/LSUHSC SBHC** or with the New Orleans Health Department at (504) 658-2500. You will not be penalized for filing a complaint.

#### ***Revoking Permission to Disclose Medical Information***

If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

By signing below, you are affirming your receipt of the enclosed **HIPAA NOTICE OF PATIENT PRIVACY PRACTICES**. Please return only this signature page.

NAME: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

STUDENT(S) NAME / GRADE LEVEL:  
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