

**LCHHSC/HHCSSLIC/SFY  
NOTICE OF PRIVACY PRACTICES**

**April 1, 2003**

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

Your privacy is a high priority for us and it will be treated with the highest degree of confidentiality. This Notice applies to all information and records related to your care that we have received or created. It extends to information received or created by our employees, staff, volunteers, physicians and health care personnel. This Notice informs you about the possible uses and disclosures of your protected health information. It also describes your rights and obligations regarding your protected health information.

In order for us to be able to provide you with the best service and care, we need to receive protected health information from you. However, we want to emphasize that we are committed to maintaining the privacy of this information in accordance with state and federal laws.

We are required by law to:

- Maintain the privacy of your protected health information;
- Provide to you this detailed Notice of our legal duties and privacy practices relating to your protected health information; and
- Abide by the terms of the Notice that is currently in effect. We reserve the right to change the terms of this Notice and make the new Notice provisions effective for all protected health information that the Agency maintains.

**PROTECTED HEALTH INFORMATION**

While receiving care from the Agency, information regarding your health care history, treatment, and payment for your health care may be originated and/or received by us. State and federal law protects information that can be used to identify you and which relates to your health care or your payment for health care. This is your protected health information.

**COLLECTING INFORMATION**

We collect protected information about you to help us provide the best service, assistance and care, provide billing services and fulfill legal and regulatory requirements. The type of information the Agency may receive from you varies according to the assistance and care that you may need.

If we become aware that an item of your protected health information may be materially inaccurate, we will make a reasonable effort to re-verify its accuracy and correct any error as appropriate.

## **SECURITY STANDARDS**

We continue to assess new technology to evaluate its ability to provide additional protection for your protected health information. We maintain physical, electronic and procedural safeguards that comply with state and federal standards to guard your protected health information.

## **USING AND DISCLOSING YOUR PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS**

We have described the uses and disclosures below and provide examples of the types of uses and disclosures we may make in each of these categories.

**For Treatment.** We will use and disclose your protected health information in providing you with treatment and services. We may disclose your protected health information to Agency and non-Agency personnel who also may be involved in your care, including, but not limited to, physicians, nurses, nurse aides, and physical therapists. Our workforce has access to such information on a need to know basis. For example, a nurse caring for you will report any change in your condition to your physician. Your physician may need to know the medications you are taking before prescribing additional medications. It may be necessary for the physician to inform the nurses or staff of the medications you are taking so they can administer the medications and monitor any possible side effects. In addition, we may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services which may be of interest to you.

We may also disclose protected health information to individuals who will be involved in your care after you leave the Agency. Anyone who has access to protected health information is required to protect it and keep it confidential.

**For Payment.** We may use and disclose your protected health information so that we can bill and receive payment for the treatment and services you receive at the Agency. Bills requesting payment will usually include information which identifies you, your diagnosis and any procedures performed or supplies used. For billing and payment purposes, we may disclose your protected health information to your legal representative, an insurance or managed care company, Medicare, Medicaid or another third party payor. For example, we may contact Medicare or your health plan to confirm your coverage or to request prior approval for a proposed treatment or service.

**For Health Care Operations.** We may use and disclose your protected health information for Agency operations. These uses and disclosures are necessary to monitor the health status of clients, manage the Agency and monitor the quality of our care. For example, we may use protected health information to evaluate our Agency's services, including the performance of our staff. In addition, we may release your protected health information to another individual or covered

entity for quality assessment and improvement activities or for review of or evaluation of health care professionals.

Health Care Operations may also include the use of information for quality assurance, training, accreditation, medical review, auditing and business planning.

## **USING AND DISCLOSING PROTECTED HEALTH INFORMATION FOR OTHER SPECIFIC PURPOSES**

### **AGENCY CULTURE**

Individuals Involved in your care or payment for your care. Unless you object, we may disclose your protected health information to a family member, a close personal friend, your legal representative and any clergy, who are involved in your care. You may restrict or prohibit these uses and disclosures by notifying the Agency in writing of your restriction or prohibition.

Emergencies. In the event of an emergency or your incapacity, we will do what is consistent with your known preference (if any), and what we determine to be in your best interest. We will inform you of uses or disclosures of protected health information under such circumstances and give you an opportunity to object as soon as practicable.

Disaster Relief. We may disclose your protected health information to an organization assisting in a disaster relief effort.

As Required By Law. We will disclose your protected health information when required by law to do so.

Public Health Activities. We may disclose your protected health information for public health activities. These activities may include, for example:

- reporting for preventing or controlling disease, injury or disability;
- reporting deaths;
- reporting abuse or neglect of a dependent adult;
- reporting reactions to medications or problems with products;
- notifying a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition; or
- disclosing for certain purposes involving workplace illness or injuries.

Reporting Victims of Abuse, Neglect or Domestic Violence. We may use or disclose protected health information to protective services or social services agency or other similar government authorities, if we reasonably believe you have been the victim of abuse, neglect or domestic violence.

Health Oversight Activities. We may disclose your protected health information to a health oversight agency for oversight activities authorized by law. These may include, for example, audits, investigations, inspections and licensure actions, judicial/administrative proceedings to which you are not a party, or other legal proceedings. In most cases, the oversight activity will be for the purpose of overseeing the care rendered by the Agency or the Agency's compliance with certain laws and regulations. The Agency does not control or define what information is needed by the health oversight agencies.

Judicial and Administrative Proceedings. We may disclose your personal health information in response to a court or administrative order. We may also disclose information in response to a subpoena, discovery request, or other lawful legal process; efforts will be made to contact you regarding the request or to obtain an order or agreement protecting the information.

Law Enforcement. We may also release your protected health information to law enforcement officials for the following purposes:

- Pursuant to a court order, warrant, subpoena/summons, or administrative request;
- Identifying or locating a suspect, fugitive, material witness or missing person;
- Regarding a crime victim, but only if the victim consents or the victim is unable to consent due to incapacity and the information is needed to determine if a crime has occurred, non-disclosure would significantly hinder the investigation, and disclosure is in the victim's best interest;
- Regarding a decedent, to alert law enforcement that the individual's death was caused by suspected criminal conduct; or
- For reporting suspected criminal activity.

Coroner, Healthcare Examiners, Funeral Homes. We may release your personal health information to a coroner, medical examiner, and funeral director. We may also release information to an organization involved in the donation or organs if you are an organ donor.

## **YOUR RIGHTS**

You have the following rights regarding your protected health information at the Agency:

- The right to receive notice of our policies and procedures used to protect your protected health information;
- The right to request that certain uses and disclosures of your protected health information be restricted;
- The right to access your protected health information;
- The right to request that your protected health information be amended;
- The right to obtain an accounting of certain disclosures by us of your protected health information for the past six years after April 13, 2003;

- The right to revoke any prior authorizations for use or disclosure of protected health information, except to the extent that the Agency has acted on your Authorization; and
- The right to request the method by which your protected health information is communicated.

## **OUR RIGHTS**

- We have the right not to agree to your requested restrictions on the use or disclosure of your personal health information. If we do agree to accept your requested restrictions, we will comply with your request except as needed to provide you with emergency treatment.
- We have the right to deny your request to inspect or receive copies of your protected health information in certain circumstances.
- We have the right to deny your request for amendment of protected health information if it was not created by us, if it is not part of your personal health information maintained by us, if it is not part of the information to which you have a right of access, or if it is already accurate and complete, as determined by us.

## **AUTHORIZATION**

Uses and disclosures of your protected health information not allowed by law under our Notice of Privacy Practices will only be made with your authorization. You can revoke the Authorization as described in your written Authorization. If you revoke your Authorization, we will no longer use or disclose your protected health information for the purposes covered by the Authorization, except where we have already relied on the Authorization.

## **COMPLAINTS**

If you believe your privacy rights have been violated you may file a written complaint with our Privacy Official at 800 N.W. 17<sup>th</sup> Avenue, Delray Beach, Florida 33445-2583, phone (800) 543-3491. The Privacy Official will review and respond to you in a timely manner. At any time, you can contact the Office of Civil Rights in the U.S. Department of Health and Human Services.

Office of Civil Rights:      107 East Madison Street  
MSC 150 Caldwell Building  
Tallahassee, FL 32399-4129  
EO Officer: Peter de Haan  
ADA Coordinator: Sheila Martin  
Ph: (850) 921-3205  
Fax (850) 921-3122  
Email: [civil.rights@awi.state.fl.us](mailto:civil.rights@awi.state.fl.us)

You will not be retaliated against for filing a complaint.

## **CHANGE TO THIS NOTICE**

We will promptly revise and distribute this Notice whenever there is a material change to the permitted uses or disclosures, your individual rights, our legal duties, or other privacy practices stated in this Notice. We reserve the right to change this Notice and to make the revised or new Notice provisions effective for all protected health information already received and maintained by the Agency as well as for all protected health information we receive in the future. We will post a copy of the current Notice in the Agency. In addition, we will provide a copy of the revised Notice to all Clients.

## **ACKNOWLEDGMENT**

We request that you sign an Acknowledgment of Receipt of Life Care Home Health Services Corp. Notice of Privacy Practices, attached as Exhibit A.

## **CONTACT INFORMATION**

If you have any questions about this Notice or would like further information concerning your privacy rights please contact:

Privacy Official  
800 NW 17<sup>th</sup> Avenue  
Delray Beach, FL 33445  
800-543-3491

**ACKNOWLEDGMENT OF RECEIPT OF  
LCHHSC/HHCSLLC/SFY'S  
NOTICE OF PRIVACY PRACTICES**

I, \_\_\_\_\_, acknowledge that I have received a copy of LCHHSC/HHCSLLC/SFY's Notice of Privacy Practices which summarizes the ways my health information may be used and disclosed by LCHHSC/HHCSLLC/SFY and states my rights with respect to my protected health information. I understand LCHHSC/HHCSLLC/SFY has the right to revise these information practices and to amend the Notice of Privacy Practices. I have been informed that in the event LCHHSC/HHCSLLC/SFY changes this Notice, a revised Notice will be posted at \_\_\_\_\_ and that I may obtain a current Notice of Privacy Practices at any time from \_\_\_\_\_.

\_\_\_\_\_  
Signature of Client  
Date: \_\_\_\_\_

\_\_\_\_\_  
Witness  
Date: \_\_\_\_\_

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Signature of Legal Representative, if Client is legally incompetent or incapacitated

\_\_\_\_\_  
Printed Name of Legal Representative

\_\_\_\_\_  
Relationship to Client

\_\_\_\_\_  
Witness  
Date: \_\_\_\_\_