



## City of Central Falls

### Office of Constituent Services & Health

## NOTICE OF PRIVACY PRACTICES

### Multidisciplinary Team

**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 the health information privacy practices of the Office of Constituent Services & Health (OCS&H), its staff and affiliated health care & service providers who jointly perform health care related services with medical groups, including physicians and local social service agencies. You will be able to obtain your own copies of our current notice by accessing our website at [www.centralfallsri.us](http://www.centralfallsri.us) or calling the Director at 401-616-2451 or emailing Zuleyma Gomez at [Zgomez@centralfallri.us](mailto:Zgomez@centralfallri.us).

*If you have any questions about this notice or would like further information, please contact the above referenced person.*

### **WHAT HEALTH INFORMATION IS PROTECTED:**

We are committed to protecting the privacy of information we gather about you while providing health-related services. Some examples of protected health information include information indicating that you are a patient of a medical group or receiving health-related services from a facility, information about your health condition, genetic information, or information about your health care benefits under Medicare, Medicaid and/or an insurance plan, each when combined with identifying information, such as your name, address, social security number or phone number.

### **REQUIRED DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION:**

*In certain circumstances, we are required to disclose your protected health information.*

**Disclosures to You:** We are required to disclose your protected health information to you, or your personal representative upon your request. A personal representative is an individual who has been designated by you and who has qualified for such designation in accordance with relevant law (and provides adequate documentation). Disclosures to OCS&H. We are required to disclose your protected health information to the U.S. Department of Health and Human Services to determine our compliance with the Health Insurance Portability and Accountability Act (HIPAA), a federal privacy law.

### **HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR WRITTEN AUTHORIZATION:**

*There are some situations when we do not need your written authorization before using your health information or disclosing it to others, including:*

1. **Treatment:** We may disclose your protected health information to a health care provider, or to an individual who manages or coordinates the provision of health care, for the purpose of providing you with treatment.
2. **Health Care Operations:** We may use your health information or disclose it to others to conduct our business operations. For example, we may use your health information to evaluate the performance of our staff in servicing you, or to educate our staff on how to improve the services they provide for you.
3. **Business Associates:** We may disclose your health information to contractors, agents, and other “business associates” with whom we collaborate to coordinate the care of people in Central Falls or carrying out our business operations. 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. If our business associate discloses your health information to a subcontractor or vendor, the business associate is required to have a written contract to ensure that the subcontractor

or vendor also protects the privacy of the information.

4. **Friends and Family Designated to be**

**Involved in Your Care:** If you do not object, we may disclose your health information to a family member, relative, or close friend who is involved in your care or payment for your care, including following your death. We may reasonably infer from the circumstances that you would not object to the disclosure.

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

6. **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 under law, such as controlling disease or public health hazards. 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 permitted by law. We may disclose a child's proof of immunization to a school, if required by State or other law, if we obtain and document the agreement for disclosure from the parent, guardian, person acting in loco parentis, an emancipated minor, or an adult.

7. **Victims Of Abuse, Neglect or Domestic Violence:** We may release your health information to a public health authority authorized to receive reports of abuse, neglect, or domestic violence.

8. **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. We may also disclose your information in response to a subpoena, discovery request, or other lawful request by someone else involved in the dispute, but only if required judicial or other approval or necessary authorization is obtained.

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

certain reasons, such as complying with court orders, assisting in the identification of fugitives or the location of missing persons, if we suspect that your death resulted from a crime, or if necessary, to report a crime that occurred on our property or off-site in a medical emergency.

10. **To Avert a Serious and Imminent Threat To Health Or Safety:** We may use your health information or disclose it to 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 disclose your information only to 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).

11. **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.

12. **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.

13. **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 officers 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.

14. **Workers' Compensation:** We may disclose your health information for workers' compensation or similar programs that provide benefits for work-related injuries.
15. **Coroners, Medical Examiners and Funeral Directors:** In the event of your death, we may disclose your health information to a coroner or medical examiner. We may also release this information to funeral directors as necessary to carry out their duties.
16. **De-identified Information or Information That Constitutes a Limited Data Set:** 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 "deidentified." We may also use and disclose health information about you that constitutes a "limited data set" 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. A limited data set 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).
17. **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.
18. **Changes to this Notice:** We reserve the right to change this notice at any time and to make the revised or changed notice effective in the future. We will make the revised notice available on our website and notify you of any material changes to the notice.

#### **REQUIREMENT FOR WRITTEN AUTHORIZATION**

For purposes other than those described above, generally, we will obtain your written authorization before using your health information or disclosing it to others outside of OCS&H. **There are certain situations where we must obtain your written authorization**

#### **before using your health information or disclosing it, including:**

**Marketing:** Unless we obtain your authorization, we may not disclose any of your health information for marketing purposes if OCS&H receives direct or indirect financial remuneration not reasonably related to our cost of making the communication.

**Sale of Protected Health Information:** Unless we obtain your authorization, we will not sell your protected health information to third parties. The sale of protected health information, however, does not include a disclosure for public health purposes, for research purposes where we will receive remuneration only for our costs to prepare and transmit the health information, for treatment and payment purposes, for the sale, transfer, merger or consolidation of all or part of our operations, to a business associate or its subcontractor to perform health care functions on our behalf, or for other purposes as required by law.

**Psychotherapy Notes:** Unless we obtain your authorization, we will not disclose information contained in psychotherapy notes (which we rarely, if ever, maintain). If you provide us with written authorization for the above or any other disclosures, 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 write to the Privacy Officer at the address given above. You may also initiate the transfer of your records to another person by completing a written authorization form.

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

*You have the following rights to access and control your health information:*

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, including medical and billing records. To inspect or obtain a copy of your health

information, please submit your request in writing to the Deputy Director at the address given above. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing or other supplies we use to fulfill your request. If your protected health information is maintained in an electronic health record, then you may receive a copy of this information in electronic format.

**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 for as long as the information is kept in our records by writing to the Deputy Director at the address given above. Your request should include the reasons why you think we should make the amendment. If we deny part or your entire 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.

**3. Right to An Accounting of Disclosures:** You have a right to request an “accounting of disclosures,” which is a list with information about how we have disclosed your health information to others within the past 6 years. We are not required to provide you with accounting of disclosures (1) for purposes of treatment, payment, or health care operations, (2) made to you or your personal representative, (3) made pursuant to your authorization, (4) made to family involved in your care in the presence of an emergency, (5) for national security or intelligence purposes, and (6) as part of a limited data set. To obtain a request form for an accounting of disclosures, please write to the Deputy Director at the address given above. You have a right to receive one list every 12-month period for free. However, we may charge you for the cost of providing any additional lists in that same 12-month period.

**4. Right to Receive Notification of a Breach:** You have the right to be notified if there is a compromise of your unsecured protected health information within sixty (60) days of the discovery of the breach. The notice will include a description of what happened, including the date, the type of information involved in the breach, steps you should take to protect yourself from potential harm, a brief description of the

investigation into the breach, mitigation of harm to you and protection against further breaches and contact procedures to answer your questions.

**5. Right to Request Restrictions:** You have the right to request that we further restrict the way we use and disclose your health information to treat your condition, run our normal business operations or disclose information about you to family or friends involved in your care. The request for restriction will only be applicable to that service. You will have to request a restriction for each service thereafter. To request restrictions, please write to the Deputy Director at the address given above. The restrictions required to agree to your request for a restriction, and in some cases the restriction you request may not be permitted under law. However, 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. 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 if we notify you before doing so.

**6. Right to Request Confidential Communications:**

You have the right to request that communications of your protected health information be sent to you at another location or by alternative means if you indicate that disclosure by the regular means could pose a danger to you and specify a reasonable alternative address or method of contact. For example, you may request we call you at work instead of sending information to your home. We will accommodate all reasonable requests.

**7. Right to Have Someone Act on Your Behalf:** You have the right to name a authorized 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. We may elect not to treat the person as your authorized representative if there is a reasonable belief that you have been, or may be, subjected to abuse, violence, or neglect by such person or that treating such person as your authorized representative could endanger you. Furthermore, we may determine, in the exercise of

professional judgment, that it is not in your best interest to treat the person as your authorized representative.

questions or concerns about the ways these types of information may be used or disclosed, please speak with your health care provider.

**8. Right to Obtain a Copy of Notices:** If you are receiving this notice electronically, you have the right to a paper copy of this notice.

**9. Right to File a Complaint:** If you believe your privacy rights have been violated, you may file a complaint with us by calling the Deputy Director at 401-616-2451 or writing to Zuleyma Gomez, Deputy Director, at 580 Broad Street, Central Falls, RI. We will not withhold services or act against you when filing a complaint.

**10. Use and Disclosures Where Special Protections May Apply:** Some kinds of information, such as HIV-related information, alcohol and substance abuse treatment information, mental health information, and genetic information, are considered so sensitive that state or federal laws provide special protections for them. For example, we are prohibited from using your genetic information for underwriting purposes. Therefore, some parts of this general Notice of Privacy Practices may not apply to these types of information. If you have



**CITY OF CENTRAL FALLS  
OFFICE OF CONSTITUENT SERVICES AND HEALTH**

**ACKNOWLEDGMENT**

*By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the City of Central Falls.*

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Signature of Patient or Authorized Representative

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Print Name of Patient or Authorized Representative

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Date

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Description of Authorized Representative's Authority