MICCOSUKEE HEALTH DEPARTMENT

P.O.BOX 440021
TAMIAMI STATION
MIAMI, FL 33144

RECEIPT OF NOTICE OF HIPPA PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, _____, have reviewed and/or received a copy of Notice of **HIPPA** Privacy Practices for:

MICCOSUKEE HEALTH DEPARTMENT
P.O. BOX 440021
TAMIAMI STATION
MIAMI, FL 33144
Phone: (305) 894-2387 and (305) 223-8380, Ext. 2262

_____ _____
Signature of Patient/Guardian Date

_____ _____
Signature of Guardian/Witness Date

OFFICIAL USE ONLY

In lieu of the patient's signature for Acknowledgement of receipt of the Miccosukee Health Department, I attempted to obtain the patient's signature in acknowledgement on this Notice of **HIPPA** Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____

Reason: _____

HIPAA NOTICE OF PRIVACY PRACTICES
THIS NOTICE DESCRIBES THE LIMITS OF HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

MICCOSUKEE HEALTH DEPARTMENT
P.O.BOX 440021
TAMIAMI STATION
MIAMI, FL 33144
Phone: (305) 894-2387

WHO WILL FOLLOW THIS NOTICE
Our employees, staff, other medical and office personnel including Health Care providers from our office.

YOUR HEALTH INFORMATIONS
This notice applies to the information and records we have about your health, health status, and the health care and services you receive at this office. It will tell you about the limits of how we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU
For Treatment
We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that the doctor can help determine the most appropriate care for you. Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as Phoning/Facing in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have.

For Payment
We may use and disclose health information about you so that the medical/dental treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party as appropriate. For example, we may need to give your health plan information about a service you received so your health plan will pay or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

For Health Care Operations
We may use health information data about you for evaluation of program services and needs to ensure continuous quality services. This includes disclosure to other Tribal departments as deemed necessary.

Appointment Reminders
We may contact you as a reminder that you have an appointment for treatment or medical care.

Treatment Alternatives
We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health Related Products and Services

We may tell you about health related products or services that may be of interest to you. Please notify us if you do not wish to be contacted for appointment reminders or if you do not wish to receive communications about treatment alternatives or health related products and services or other healthcare information like our diabetes outreach information to diabetics. If you advise us in writing (at the address listed at the front of this Notice) that you do not wish to receive such communications, including mail-outs, we will not use or disclose your information for these purposes. You may revoke your Consent at any time by giving us written notice. Your revocation will be effective when we receive it, but it will not apply to any uses and disclosures which occurred before that time.

SPECIAL SITUATIONS

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations.

To Avert a Serious Threat to Health or Safety

We may use and disclose health 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 as approved by the Business Council.

Required by Law

We will disclose health information about you when required to do so by applicable law as reviewed/approved by the Business Council.

Research

We may use and disclose health information about you for research projects that are subject to a special Tribal approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

Public Health Risks/Health Oversight Activities

We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability, or report births, deaths, suspected abuse or neglect, non-accidental physical injuries reactions to medications or problems with products.

We may disclose health information to a health oversight agency for audits, investigations or inspections. These disclosures may be necessary to monitor the health care system.

Lawsuits and Disputes

If you are involved in a lawsuit or dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements we may also disclose health information about you in response to a subpoena. Disclosure of any information about you as it relates to any lawsuit or dispute will be disclosed ONLY with the prior approval of **Tribal Administration Business Council**, at least to immune documents.

Law Enforcement

We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant summons or similar process, subject to all applicable legal requirements.

Family and Others Involved in Your Care

We may disclose health information about you to your family members, or others involved in your care, if we obtain your verbal consent or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family, or others involved in your care, if we can infer from the circumstances based on our professional judgment, that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed. In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency) we may, using our professional judgment, determine that a disclosure to your family member or others involved in your care is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf, such as to pick up filled prescriptions, medical supplies, or X-rays.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written Authorization. We must obtain your Authorization separate from any Consent we may have obtained from you, if you give us Authorization to used or disclose health information about you, you may revoke that Authorization, in writing, at any time. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

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

Right to inspect and Copy

You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to our privacy official in order to inspect and/or copy your health information. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed.

Right to Amend

If you believe 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 as long as the information is kept by this office. To request an amendment, you must complete and submit a document entitled "Medical Record Amendment/Correction Form" to our designated HIPPA Coordinator. The request for an amendment to your health information MUST be in writing AND include the reason for your request, or it will be denied. Your request may also be denied IF:

a) We did not create the record that contains the information you are seeking to amend. However, if the person or entity that created the information is no longer available to make the amendment for you, we may be able to amend the information in our records only;
b) The information you are seeking to amend is not part of the health information that we keep and is therefore not under our control;
c) The information is contained in documents you would not be permitted to inspect and copy; and
d) The information is accurate and complete and any attempt to amend the information would make your medical information inaccurate.

Right to an Accounting of Disclosures

You have the right to request an "accounting of disclosures." This is a list of the disclosures we make of medical information about you for purposes other than treatment, payment and health care operations. To obtain this list, you must submit your request in writing to our HIPPA Coordinator. The request must be for a period of time no longer than six years in length and is available only for disclosures made AFTER April 14th, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically (i.e., e-mail, USB, etc…).

Right to Request Restrictions

You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are Not Required to Agree to Your Request

If we agree to your request for restrictions or limitation on your health information, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you may obtain from our HIPPA Coordinator a form entitled **"Request for Restricting Uses and Disclosures and Confidential Communications Information Form."** This must be filled out and returned to our HIPPA Coordinator for consideration.

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. To request confidential communications, you may complete and submit a form entitled **"Requests for Restricting Uses and Disclosures and Confidential Communications"** from our HIPPA Coordinator. We will accommodate all reasonable requests. Your request must state the manner or place where you wish to be contacted.

Right to a Copy of This Notice

You have the right to a copy of this notice at any time, or via (i.e., email or USB).

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and 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. We will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our HIPPA Coordinator or with the Department of Health and Human Services without penalty or retribution.