

Palos Hospital
NOTICE OF PRIVACY PRACTICES

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 respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you this notice of our privacy practices (“Notice”). This Notice describes how we protect your health information and what rights you have regarding information. References to “we,” “us,” and “our” include Palos Hospital and the members of its affiliated covered entity, including Palos Medical Group and Palos Imaging. An affiliated covered entity is a group of organizations under common ownership or control who designate themselves as a single affiliated covered entity for purposes of compliance with the Health Insurance Portability and Accountability Act (“HIPAA”). Palos Hospital, Palos Medical Group and Palos Imaging and their employees and workforce members who are involved in providing and coordinating health care are all bound to follow the terms of this Notice. The members of Palos Hospital’s affiliated covered entity will share PHI with each other for the treatment, payment and health care operations of the affiliated covered entity and as permitted by HIPAA and this Notice.

MY HEALTH INFORMATION

- A. I agree that Palos Community Hospital can create recordings and images containing my health information for treatment, education and Palos Community Hospital, Palos Medical Group and Palos Imaging operations as described in this Notice of Privacy Practices.
- B. If I am an obstetrical patient, I understand that Palos Community Hospital and Palos Medical Group may use and release my health information for the care and treatment of my newborn child/children, for related payment and for healthcare operations. I understand that my health information will be included in my newborn child/children’s medical records.
- C. The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) is a law that protects the privacy and security of my health information anywhere in the United States. There are other federal laws, as well as Illinois state laws, that protect “special” health information including information relating to HIV/AIDS; behavioral or mental health; developmental disabilities; treatment for substance (alcohol and/or drugs) use disorder; genetic testing and counseling; artificial insemination; sexual assault/abuse; domestic abuse of an adult with a disability; child abuse and neglect; and, if I am a minor, sexually transmitted illnesses, pregnancy and birth control.
- D. If my consent is required by law, I agree that Palos Community Hospital (PCH) and Palos Medical Group (PMG) and Palos Imaging (PI) may use and disclose my special health information within for treatment, payment and their operations in the same way that HIPAA and other laws allow PCH, PMG and PI to use or disclose my other health information for these purposes and as described in this Notice of Privacy Practices.
- E. If my consent is required by law, I also agree that PCH, PMG and PI may further re-disclose my special health information (1) to researchers for research purposes in accordance with law and as described in this Notice of Privacy Practices, (2) to regulators for required disease or other state law reporting; and (3) to non-PCH or non-PMG or non-PI providers for treatment, payment and healthcare operations purposes. “Non-Palos” providers may include other, non-related or affiliated providers participating in the Epic Care Everywhere® program as described further in this Notice of Privacy Practices (unless I have otherwise opted not to participate in the Care Everywhere program), EpicCare® Link, Epic Carequality or similar programs allowing for the exchange of health information between providers for treatment purposes. I may opt out of the Epic Care Everywhere® program by telling the registrar at my physician’s office or by contacting PHCareEverywhereAssistance@paloshealth.com.
- F. I agree that the consents and permissions set forth in this Section apply to all my special health information in PCH’s, PMG’s and PI’s possession, including information concerning care received prior to or after the date of this

form. I also understand that I may revoke the consents set forth in this Section by providing written notice to PHCareEverywhereAssistance@paloshealth.com and I understand that if I revoke the consents, it will not apply to any uses and releases of my health information already made by PCH, PMG and PI before my revocation. This means that my special health information will become part of my electronic medical record and remain in that record even if I revoke my consent. The permissions I have given in this Section will expire one (1) year from the date that I sign this form unless I provide notice to PHCareEverywhereAssistance@paloshealth.com. I understand that if I revoke the consents, it will not apply to any uses and releases of my health information that occurred prior to my written notice of a change. I understand that I have the right to inspect and copy any of my special health information to be used or disclosed.

USES AND DISCLOSURES WITHOUT PERMISSION

Treatment, Payment and Health Care Operations. The most common reason why we use or disclose your health information is for treatment, payment or health care operations.

Treatment: We may use or disclose your information to treat you. For example, we may use or disclose your information to schedule an appointment for you; perform diagnostic tests, prescribe medications and fax or send them electronically to be filled; refer you to another health care provider for additional or specialist services; or get copies of your health information from another health care provider that you may have seen before.

Payment: We may use or disclose your information to obtain payment for the services we provide to you. For example, we may use or disclose your information to ask you or your insurance company about your health insurance coverage or other sources of payment; to prepare and send bills or claims; or to collect unpaid amounts (either ourselves or through a collection agency or attorney).

Health Care Operations: We may use or disclose your information for certain administrative and managerial activities that are necessary for us to run our organization. For example, we may use or disclose your information to train or evaluate our staff; to conduct financial or billing audits; to conduct internal quality assurance; to participate in managed care plans; to defend legal matters; to conduct business planning; and to contract for storage of our records.

Disclosures Unless You Object.

Unless you instruct us not to, we may release medical information about you to a friend, family member or member of the clergy who is involved in your medical care.

We participate in the “Epic Care Everywhere” program and other similar programs that allow clinicians from different organizations across the country to electronically and securely exchange patient medical information for treatment purposes. The benefit to you with participating in these programs is that each of your participating caregivers will have access to medical information that may be available from other participating caregivers when providing care to you. If you do not wish to participate in Care Everywhere or similar programs, notify our registration personnel or send an e-mail to PHCareEverywhereAssistance@paloshealth.com

While you are a hospital patient we will include your name, location, your general condition and your religious affiliation in the hospital directory, unless otherwise instructed. The directory information, except your religious affiliation, will be disclosed to people who ask for you by name. If you request to opt out of the directory, we cannot inform visitors of your presence, location, or general condition.

Other Uses and Disclosures

In some limited situations and if certain conditions are satisfied, we may also use or disclose your information without your permission. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;

- to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to report or provide information about a crime;
- to a medical examiner to identify a dead person or to determine the cause of death; or to a funeral director to aid in burial; or to organizations that handle organ or tissue donations;
- for health related research;
- to prevent a serious threat to health or safety;
- for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who agree to comply with privacy and security laws and regulations that apply to them.
- for fundraising; we may contact you for fundraising purposes to support Palos Health and its mission, but you can tell us not to contact you again for this purpose.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments or the need to make a routine appointment. We may also call, write, or E-mail to notify you of other treatments or services available that might help you.

OTHER USES OF YOUR MEDICAL INFORMATION

In any other situation, we will request your written authorization before using or disclosing any identifiable health information about you. We may not use or disclose psychotherapy notes (private notes of mental health professional kept separately from a medical record) contained in your protected health information without your written authorization. We may not sell your protected health information or use or disclose your protected health information for marketing purposes, where remuneration is received, without your written authorization. If you choose to sign an authorization to disclose information, you can later revoke your authorization in writing to stop any future uses and disclosures.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Right to Request Restrictions on Uses and Disclosures: You have the right to request that we limit the use and disclosure of medical information about you for treatment, payment and healthcare operations. We are not required to agree to your request with one exception outlined below. If we agree to your request, we must follow your restrictions (except if the information is necessary for emergency treatment or in situations where we are legally required or allowed to make a use or disclosure). Your request for restrictions must be made in writing and submitted to the Privacy Officer via the contact information at the end of this Notice.

By law, we must agree to your request to restrict disclosure of your medical information to a health plan if the disclosure is a) for the purpose of carrying out payment or health care operations, b) is not otherwise required by law, and c) for an item or service you have paid for in full, out-of-pocket. Once you have requested such restriction in writing, and your payment in full has been received, we must follow your restriction, absent an emergency or a situation where we are required by law to disclose such information.

Right to Inspect and Obtain a Copy of Your Health Information: Patients have a right to look at their own medical information and to get a copy of that information. This includes your medical record, your billing record, and other records we use to make decisions about your care. Medical information that is available electronically may be obtained in that format. To request your medical information, please contact the Release of Information desk at (708) 923-8660. If you wish to obtain a copy of your health information, your written authorization is required prior to receiving the records. There will be a charge for obtaining a copy of your records as allowed for by the State of Illinois.

Right to Request an Accounting of Disclosure: You also have the right to receive an accounting of instances where we have disclosed health information about you for reasons other than treatment, payment or related administrative purposes. To receive an accounting, please contact the Privacy Officer via the contact information at the end of this Notice. The first accounting will be provided to you for free, but you may be charged for any additional accountings requested during the same year. You will be notified in advance what these additional accountings will cost.

Right to Amend: If you believe that information in your record is incorrect or if important information is missing, you have the right to request in writing that we correct the existing information or add the missing information. To ask to amend your medical information, please contact the Director of Health Information Management at (708) 923-4664. We may deny your request to amend information if the information was not created by us, maintained by us, or if we determine the information is accurate. You may appeal in writing a decision by us not to amend your information.

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. You must make your request in writing to Medical Records. We will accommodate all reasonable requests.

Right to a Paper Copy of This Notice: You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

Right to Receive Notice of a Breach: You have the right to be notified in writing following a breach of your medical information that is not secured in accordance with certain security standards.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices. We reserve the right to change this Notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to all health information that we maintain. If we change our Notice of Privacy Practices, we will post the new Notice in our office, have copies available in our office, and post it on our Web Site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or to the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or e-mail shown at the end of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, please contact:

Palos Hospital
Privacy Officer
12251 S. 80th Ave.
Palos Heights, IL 60463
708-923-4162
privacyofficer@paloshealth.com