



## Notice of Privacy Practices

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

Dear Patient,

We have long been committed to protecting patient privacy. As part of this commitment, we follow federal and state law which requires us to maintain the privacy of your health information and to provide you with this Notice of our privacy practices. When we use or disclose your health information, we are required to follow the privacy practices described in this Notice (or other notice in effect at the time of the use or disclosure).

We must follow either federal or state law, whichever is more protective of your privacy rights. For example, if federal law allows certain disclosures of your health information without your written authorization, but state law does require your written authorization for such disclosures, we must follow state law.

We reserve the right to change the privacy practices described in this Notice at any time. Changes to our privacy practices would apply to all health information we maintain. Changes to this Notice will be posted in our office. You may request a copy of our current Notice at any time.

### **USE AND DISCLOSE OF YOUR HEALTH INFORMATION**

We have described below the different ways we use and disclose health information:

**Treatment.** We may use or disclose your health information to provide treatment and other services to you. For example, a doctor may use the information in your medical record to diagnose your injury or illness and determine which treatment option, such as medication or surgery, best addresses your health needs. In addition, we may use your health information for appointment reminders or to send you information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may disclose your health information to other health care providers involved in your treatment.

**Payment.** We may use and disclose your health information to obtain payment for services that we provide to you. For example, in order for an insurance company to pay for your treatment, we must submit a bill that identifies you, your diagnosis, and the treatment provided to you. As a result, we will provide such health information to an insurer to obtain payment for your medical bills. We may also disclose your health information to another health care provider or health plan for its payment activities – for example, for the health plan to determine your eligibility or coverage

**Health Care Operations.** We may need to use your health information to improve the quality or cost of care we deliver. These quality and cost improvement activities may include using your health information to evaluate the quality of our health care services or sharing your health information with our Patient Experience Liaisons to ensure that you have a comfortable visit with us.

**Health Care Operations (continued)** We may also disclose your health information to another health care provider or health plan that has or had a relationship with you for their health care operational activities, such as for the other health care provider or health plan to evaluate the performance of your doctors, nurses and other health care professionals. We report immunization administration to Florida Shots Registry. We may also provide your PHI to accountants, attorneys, consultants, and to outside companies that assist Us in our operations and agree by contract to keep any PHI received from Us confidential in the same way We do.

**Business Associates.** In order for us to carry out treatment, payment or health care operations, we may disclose your health information to persons or organizations that perform a service for us, or on our behalf, that requires the use or disclosure of individually identifiable health information. Such persons or organizations are our business associates. For example, we may disclose your health information to an agency that accredits health care organizations or to a collection agency to collect payment of medical bills.

**Appointment Reminders.** Treatment information, and Related Benefits. We may contact you via phone, email, or text message to provide appointment reminders or information about treatment or other health related benefits and services.

**Individuals Involved In Your Care.** We may disclose your location, condition, or death to designated emergency contacts for care.

**Student Counseling Services.** I understand that Counseling and Medical Services will share Protected Health Information (PHI) with each other as necessary to carry out treatment or health care operations. We will do so through access to a shared electronic medical record.

**The University of Tampa.** I understand that if there is a health, or safety risk to the University of Tampa community that requires my medical or psychological condition to be shared with the Dean of Students' staff, and this will be done without additional consent on my part. If I am diagnosed with a communicable disease, I understand that my professors will be notified of my condition and informed that I will remain out of classes and dining venues on campus for a designated time frame until I am no longer contagious.



## Notice of Privacy Practices – *continued*

### OTHER USES AND DISCLOSURES

Federal privacy rules allows us to use or disclose your health information without your permission or authorization for a number of other reasons, including:

**Public Health Activities.** If required or allowed by law, we may disclose your health information for the following public health activities: (1) to report health information to public health authorities for the purpose of preventing or controlling disease, injury or disability; (2) to report information about products and services under the jurisdiction of the U.S. Food and Drug Administration; (3) to alert 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.

**Victims of Abuse, Neglect or Domestic Violence.** If we reasonably believe you are a victim of abuse, neglect or domestic violence and the reporting of such information is required or allowed by law, we may disclose your health information to a governmental authority, including a social service or protective services agency.

**Health Oversight Activities.** As required or allowed by law, we may disclose your health information to a government agency that is legally responsible for overseeing the health care system and is responsible for ensuring compliance with the rules of government health programs such as audits; civil, administrative, or criminal investigations, proceedings, actions; inspections; licensure or disciplinary actions; or other activities necessary for appropriate oversight as authorized by law.

**Judicial and Administrative Proceedings.** We may disclose your health information in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.

**Law Enforcement Officials.** We may disclose your health information to the police or other law enforcement officials as required or allowed by law.

**Health or Safety.** We may use or disclose your health information to prevent or lessen a serious and imminent threat to the health or safety of a person or the general public. Any disclosure, however, would only be to someone able to help prevent or lessen the threat.

**Specialized Government Functions.** We may use and disclose your health information for authorized national security activities or to units of the government with special functions, such as the U.S. military or the U.S. Department of State under certain circumstances.

**Coroners, Medical Examiners and Funeral Directors.** We may disclose your health information to a coroner, medical examiner or funeral director as required or allowed by law.

**Organ and Tissue Donation.** We may disclose your health information to organizations that facilitate organ, eye or tissue donation, banking or transplantation.

**Research.** There are situations when researchers and research staff may use or disclose your health information for research purposes without your authorization. Researchers may conduct research that simply involves reviewing your health information and the health information of others with similar conditions or diseases. In such situations, researchers will not contact you for your authorization, but must obtain permission from a board (called the Institutional Review Board) that is in place to ensure that the welfare and privacy of research participants is protected, as required by law. Researchers may also review your health information to determine if there are enough patients with a specific disease or condition to conduct a study or determine whether you would be a good candidate for a study that will involve interaction with you. In this situation, they may contact you to ask if you would like to participate in a study.

### USE AND DISCLOSURE WHICH YOU AUTHORIZE

In other situations not covered by this Notice, we will not disclose your health information other than with your written authorization. If you choose to later revoke your authorization in writing at any time except to the extent that we have taken action in reliance upon the authorization.

### YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

#### **Right to Request Restrictions on Certain Uses and Disclosures of Your Health Information.**

You may ask for restrictions on how your health information is used or whom your health information is disclosed. (1) for treatment, payment and healthcare operations, (2) to family or friends involved in your care or payment of medical bills, or (3) to authorities involved in disaster relief efforts. While we will consider all requests for restrictions, we are not required to agree to your request. To request restrictions on how we use and disclose your health information for the purposes described above, you must obtain a restriction request form from our Health Information Management staff and submit the completed form to them. We will send you a written response.

#### **Right to Request Restrictions on Disclosure of Your Health Information to a Health Plan.**

You have a right to request, in writing, restrictions on disclosure of your health information to a health plan if the information pertains solely to a health care item or service for which you, or someone on your behalf, has paid out-of-pocket, in full.

**Right to Receive Confidential Communications of Your Health Information.** We will accommodate any reasonable request that we communicate your Health information in different ways or places. For example, you may wish to receive your billing statement at a P.O. Box instead of a street address. We may ask you to put your request in writing.



## Notice of Privacy Practices – *continued*

**Right to Cancel Authorization to Use or Disclose Your Health Information.** You may request access to your health information in order to review or request copies of such information. In certain situations, we may deny you access to a portion of your health information (for example, mental health records or information gathered for judicial proceedings) as allowed by law. To review or obtain copies of your health information, you may review your Patient Portal in the electronic health care, you may also request your records in writing. You must obtain a Release of Information form from our Dickey Health and Wellness staff and submit the completed form to them. There is no charge for copies of your health information, including the cost of copying (including cost of supplies and labor), postage and preparing an explanation or summary of your health information. You have the right to request that the copy be provided in an electronic form or format. If the form and format are not readily producible, we will work with you to create a reasonable electronic form or format. If you decline the available electronic formats we will provide you with a paper copy.

You should note that, if you are a parent or legal guardian of a minor (child under age 18), certain portions of the minor's health information may not be accessible to you (for example, records relating to alcohol and other drug abuse treatment, HIV test results, or if the minor is emancipated).

**Right to Request to Correct Your Health Information.** You may ask us to correct your health information. While we will consider all requests for corrections, we may deny your request for legitimate reasons (for example, if your health information is accurate and complete or we did not create the health information you believe is incorrect). To request a correction to your health information, your request must be made in writing and state a reason to support the requested amendment. In certain cases, we may deny your request.

**Right to Receive a Record of Disclosures of Your Health Information.** You may ask for a list of certain disclosures of your health information made by us, in the six years prior to the date of your request. This list must include the date of each disclosure, who received the health information disclosed, a brief description of the health information disclosed, and why the disclosure was made. This list will not include disclosures made to you, or for purposes of treatment, payment, health care operations, or for certain other purposes.

**Right to Receive Paper Copy of this Notice.** You may request a paper copy of this Notice at any time, even if you earlier agreed to receive this notice electronically.

**Right to Your Own Billing Account.** You have the right to request an accounting of certain disclosures of your health information for purposes other than treatment, payment, or health care operations, or certain other disclosures we are permitted to make without your authorization as described in this notice. We are also not required to account for any disclosures that you requested or signed for in writing. The request for an accounting must be made in writing. Accounting requests may be subject to a reasonable cost-based fee.

**Right to Notification of Breach.** You have the right to be informed of a breach of your projected health information. We will notify you, within 60 days of discovery, if we breach your unsecured protected health information.

**The right to questions or complaints.** To file a complaint, please contact Assistant Vice President of Wellness, Gina Firth, Address: 401 W, Kennedy Blvd., Tampa, FL 33606, phone number (813) 257-1777. Complaints may also be submitted in writing.