

Memory and Wellness Center

Christine E. Lynn College of Nursing ~ Florida Atlantic University
777 Glades Road, AZ 79 ~ Boca Raton, Florida 33431
Office (561) 297-0502 Fax (561) 297-0505

NOTICE OF PRIVACY PRACTICES

Effective Date: September 13, 2010

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. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. This notice takes effect on September 13, 2010 and will remain in effect until we replace it. We are required to abide by the terms of the notice currently in effect.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request and on our website.

You may request a copy of our Notice at any time.

PROTECTED HEALTH INFORMATION

Definition: Individually-identifiable health information regarding the patient. Examples include (but are not limited to): diagnosis, signs and symptoms of illness, name, address, birthdate.

USES AND DISCLOSURES OF HEALTH INFORMATION

We routinely use and disclose health information about you for treatment, payment and healthcare operations, for example:

Treatment. We may disclose your health information to your physician(s) and/or other healthcare provider(s) in order to coordinate treatment for you.

Payment. We may disclose your health information in order to obtain payment from your insurance carriers(s).

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include data/information management and quality assessment and improvement activities, such as reviewing the competence of healthcare professionals or standards of care.

In addition to these routine uses and disclosures of your health information for treatment, payment or healthcare operations, we may also use and disclose your health information for the following purposes:

Your Authorization. You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Notice of Privacy Practices - continued

To a Family Member or Friend. Under circumstances of serious concern about your health and wellbeing and/or your capacity to make rational decisions in the best interest of your health and wellbeing, we may disclose your health information to your personal representative, a family member, or another responsible person to the extent necessary to obtain assistance with your healthcare or with payment for your healthcare. We may use or disclose health information to notify, or assist in the notification of (including identifying or locating), a family member, your personal representative or another responsible person, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment, disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and experience in disclosing health information to only those individuals requiring it for your health and wellbeing. Under the circumstances described above, our priority would be to disclose relevant information only to the party/parties you have identified and for whom you have given written authorization. In addition, we would restrict disclosures in accordance with agreed upon restrictions.

As Required or Allowed by Law. We may disclose your health information if we are required or permitted to do so by law. Relevant circumstances include, but are not limited to, the following: 1. to comply with a court order; 2. to report suspected child abuse or neglect; 3. to report suspected elder abuse or neglect; 4. to prevent imminent harm to you or another person or persons, 5. to report an unsafe driver. We may be legally required to report certain health information in order to prevent or control disease or to protect public health and safety.

Appointment Reminders and Correspondence. We may communicate with you to provide you with appointment reminders and correspondence (using voicemail messages, postcards, letters and reports). Please let us know if you prefer that we contact you via a specified means or location regarding your appointments and correspondence. We will comply with your request if at all possible.

Research. Given our commitment to learning more about the diagnosis and treatment of memory disorders, we may use and disclose information about you as part of an invitation to you to participate in research activities. Most research projects are conducted by our staff. We may, at times, help other researchers identify patients with specific health conditions. We may disclose your health information to researchers who have obtained necessary Institutional Review Board approval to pursue a given research project. You will always have the opportunity to consent or decline to participate in research based upon full information.

Initial one: **I do** **I do not** permit use of my personal health information for research purposes.

Fundraising. We may use information from your records, such as your name and address, to contact you about fund-raising activities for our not-for-profit operations. We will not release your information to other organizations.

Initial one: **I do** **I do not** permit use of my personal health information for invitations to fund-raising activities.

Notice of Privacy Practices - continued

PATIENT RIGHTS

Access. You have the right to look at or obtain copies of your health information, with limited exceptions. We will use the format you request unless we cannot practically do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We may charge you a reasonable, cost-based fee for expenses, such as copying, mailing and staff time.

If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice.

Disclosure Accounting. You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities, for the last six (6) years, but not before April 14, 2003. If you request this accounting more than once in a twelve (12) month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions. You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement -- except in emergency situations. Agreed upon restrictions will not affect the services you receive at the Memory and Wellness Center

Specified Communications. You have the right to request that we communicate with you about your health information by specified means or locations. You must make your request in writing. Your request must specify the means and/or location and provide satisfactory explanation as to how payments will be handled under your request.

Amendment. You have the right to request that we amend your health information. Your request must be in writing and it must explain why your record should be amended. We may deny your request under certain circumstances.

Electronic Notice. If you receive this Notice on our website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, you may file a complaint by using the contact information listed at the end of this Notice. You also may submit a written complaint to the U. S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U. S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U. S. Department of Health and Human Services.

Contact: Kathleen Valentine, PhD, RN, Privacy Officer

Address: Memory and Wellness Center – AZ 79

777 Glades Rd. – FAU

Boca Raton, FL 33431

Telephone: 561-297-0502

Fax: 561-297-0505

Email: Memorylane@fau.edu

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient's Name _____

Date of Birth _____

SECTION B: To the Patient - Please read the following statements carefully

Notice of Privacy Practices. You have the right to read our Notice of Privacy Practices before you decide whether to sign the Consent. Our Notice provides a description of our services, payment activities and healthcare operations, the uses and disclosures we may make of your protected health information, and other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. By signing below, you acknowledge that you have received a copy of our notice.

Further, we reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of the protected health information that we maintain.

Right to Revoke. You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation.

Right to Provide Service. The Louis and Anne Green Memory and Wellness Center reserves the right to decline to provide you services at any time at its discretion. If we decline to provide services to you, we will provide you with the names and contact information of other professionals who may provide comparable services to you.

I understand that by signing below I am giving my consent to the use and disclosure of my protected health information as outlined in the Notice of Privacy Practices, with any restrictions attached _____.

Signature of Patient _____ Date: _____

Signature of Legal Representative _____ Date: _____

Signature of Witness: _____ Date: _____