



NOTICE OF PRIVACY PRACTICES

Winslow Health Center operates as a single covered entity under the Health Insurance Portability and Accountability Act (HIPAA) and shall comply with the rules governing the use and disclosure of individually identifiable health information set forth in the HIPAA Privacy Regulations.

This notes describes how Protected Health Information (PHI) about you may be used and disclosed and how you may obtain access to your PHI. Please review it carefully.

1. This notice applies to all policies concerning any PHI generated by Winslow Health Center (WHC), whether medical or any other identifying information.
2. WHC is permitted to use/disclose your PHI without your consent for purposes related to treatment and healthcare operations. (*Example:* your Primary Care Provider (PCP) may disclose your PHI to another provider or facility for the purpose of a consult or additional treatment.)
3. WHC is permitted to use/disclose your PHI for emergency treatment.
4. WHC may use/disclose your PHI for the purpose of our day-to-day operations and functions. (*Example:* provide information for internal audits and quality improvements.)
5. WHC may use/disclose your PHI in special situations, as required by law. (*Examples* include when requested by law enforcement officials, to comply with worker's compensation laws, to aver serious threat to health or safety, to report information about abuse, neglect or domestic violence, for public health purposes, for health oversight activities such as inspections and licensure, for nation security purposes, to assist coroners or funeral directors with their official duties, provide information for organ donation, approved research projects that protect your privacy, and to comply with requests by the military if deemed necessary by military command authorities.

Except as described previously, disclosures of your PHI will be made only with your written authorization. You may revoke your authorization at any time, in writing.

YOUR RIGHTS

1. You have the right to request restrictions on the use/disclosure of your PHI for treatment, payment or healthcare operations purposes or notification. Winslow will honor the requested restrictions unless they go against Allegheny College policy, Pennsylvania State Law, or Federal Law.
2. You have the right to request the receipt of confidential communications about your own health information by alternative means or at alternative locations. To request alternative communications, you must submit a written request to Winslow Health Center.
3. You have the right to inspect and receive a copy of any health information about you other than mental health clinical notes, substance abuse clinical notes, or information compiled in anticipation of or for use in civil, criminal, or administrative proceedings. To arrange for access to your records or to receive a copy, you must sign a medical record release form at the appropriate affiliate office. Access may be denied if you are an inmate at a correctional institution, if you are a participant of an ongoing research program, or if access may cause harm to you or any other person. If access is denied, you have the right to have the decision reviewed by a healthcare professional who did not participate in the original decision. If access is denied, the reasons will be provided to you in writing.
4. You may request that your PHI be amended. Your request may be denied if the information in question was not created by us, is not part of our records, is not the type of information available for copying (as noted above), or if the information is accurate and complete. If your request is denied, you may submit a written record stating that you disagree with the denial, which will be kept on file and distributed with all future disclosures of the information to which it relates. A written request to amend PHI must be submitted to WHC.
5. You have the right to an accounting of any disclosures of your PHI made during the six-year period preceding the date of your request. Exceptions include disclosures for the purpose of carrying out our treatment, payment, or healthcare operations, disclosures to you or to persons involved in your care, national security or intelligence purposes, to correctional institutions, or law enforcement officials who had you in custody at the time of disclosure, disclosures that occurred prior to April 14, 2004, disclosures authorized by you, disclosures of unidentifiable information that is part of a limited data set, disclosures that are incidental to another permissible use, or disclosures to a health oversight agency or law enforcement official if the agency asks WHC not to account to you for such disclosure. The accounting will include the date, name or entity of person receiving the information, their address (if known), a brief description of the information disclosed, and the purpose of the disclosure. To request an accounting of disclosures, submit a written request to WHC.

DUTIES OF WINSLOW HEALTH CENTER

1. WHC is required by law to maintain the privacy of your PHI and to provide you this notice of our legal duties and privacy practices, and will attempt to obtain a signature annually that states you received this policy.
2. WHC is required to abide by the terms of this notice. We reserve the right to change this notice and to make these changes applicable to all health information that we maintain. Any changes to this notice will be posted at our office and will be available upon request.

COMPLAINTS

If you believe your privacy rights have been violated, any complaints should be addressed to Winslow Health Center at (814) 332-4355. If not resolved to your satisfaction, complaints may be made to the Secretary of the Federal Department of Health and Human Services, Civil Rights Division at 1-866-627-7748.

Winslow Health Center reserves the right to change this Notice and make the change effective to information we already have about you, as well as future information. We will send a copy of the current Notice via email to all effected patients/students and post a copy at WHC and the Notice will contain the current effective date.

Student Name: _____

Allegheny ID#: _____ **DOB:** _____

I have been given a copy of Winslow Health Center's *Notice of Privacy Practices* ("Notice"), which describes how my health information is used and shared. I understand that Winslow Health Center has the right to change this notice at any time. I may obtain a current copy by contacting the WHC's HIPAA Privacy Officer, or by visiting the WHC web site at sites.allegheny.edu/healthcenter.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:

Signature: _____ **Date:** _____

Signature: _____ **Date:** _____

Signature: _____ **Date:** _____

Signature: _____ **Date:** _____