

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.

The Facility is providing this Notice of Privacy Practices because the privacy of your health information is very important to you and to us, and in compliance with federal regulations. By “your health information” we mean the information that we maintain that specifically identifies you and your health status.

Summary

This Notice describes how we use your health information within the Facility and disclose it outside the Facility, and why. The Notice covers:

- Uses or disclosures which do not require your written authorization.
 - >> Treatment, payment, and health care operations.
 - >> Uses or disclosures of your health information to which you may object.
 - >> Uses or disclosures required or permitted.
- Uses or disclosures which require your written authorization.
- Your rights as a resident regarding privacy of your health information.
- Our duties in protecting your health information.
- Complaints, contact person, effective date, and acknowledgement.

Uses or Disclosures Which Do Not Require Your Written Authorization

Treatment, Payment, and Health Care Operations

We use or disclose your health information to carry out your treatment; to obtain payment for your treatment; and to conduct health care operations. For example:

- >> For treatment, we use your health information to plan, coordinate, and provide your care. We disclose your health information for treatment purposes to physicians and other health care professionals outside our facility who are involved in your care.
- >> For payment, we use your health information to prepare documentation required by your insurance company or HMO or by Medicare or Medicaid. We disclose that part of your health information that these organizations require to pay us.

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- >> For health care operations, we use or disclose your health information, for example, to improve the quality of our services, to plan better ways of treating residents, and to evaluate staff performance.

Uses or Disclosures of Your Health Information to Which You May Object

We may use or disclose your health information for the following purposes, unless you ask us not to.

- Facility directories. We maintain a resident directory including, for each resident, name, location in our facility, health condition in general terms, and religious affiliation. We may disclose this information to people who ask for you by name. We will make known your religious affiliation only to clergy.
- Informing family and friends. We may disclose your health information to family, friends, or others identified by you who are involved in your care.
- Assistance in disaster relief efforts.
- Confirming appointments.
- Informing you about treatment alternatives or other health-related benefits and services that may be of interest to you.

If you object to our use of your health information for any of these purposes please contact your Facility Privacy Officer.

Uses or Disclosures Required or Permitted

Where we are required or permitted to do so, we may use or disclose your health information in the following circumstances without your written authorization.

- Federal government investigation, when required by the Secretary of Health and Human Services to investigate or determine our compliance with federal regulation.
- Federal, state or local law requirements.
- Public health activities, for example to report communicable diseases or death; or for matters involving the Food and Drug Administration.
- Reporting of abuse, neglect or domestic violence.
- Health oversight activities by a health oversight agency. (A health oversight agency is an organization authorized by the government to oversee eligibility and compliance and to enforce civil rights laws.)
- Judicial or administrative proceedings, for example responding to a court order or subpoena.
- Law enforcement purposes, for example to report certain types of wounds or other physical injuries or to identify or locate a suspect, fugitive, material witness, or missing person.

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- Use by coroners, medical examiners, or funeral directors.
- Facilitating organ, eye, or tissue donation.
- Research, provided that very strict controls are enforced.
- Averting a serious threat to your health or safety or that of the public.
- Specialized government functions such as military or veterans' affairs; national security, and intelligence activities.
- Workers' compensation.

Uses or Disclosures Which Require Your Written Authorization

Your written authorization, which you may revoke (in writing), is required if we use or disclose your health information for any purpose other than those stated above. In particular your authorization is required if:

- We use or disclose your health information for marketing of goods or services.

Your Rights As A Resident to Privacy Of Your Health Information

- **Right to Request Restrictions**

You have the right to request restrictions on our uses and disclosures of your health information; however, we may refuse to accept the restriction.

- **Right to Request Confidential Communications**

You have the right to request in writing that we communicate with you confidentially, for example: to speak with you only in private; to send mail to an address you designate; or to telephone you at a number you designate. We will make every attempt to honor your request.

- **Right to Request Access to Your Health Information**

You have the right to request access to your health information in order to inspect or copy it. Your request must be in writing. We may deny your request and, if so, you may request a review of the denial. However, we will make every attempt to honor your request.

- **Right to Request an Amendment of Your Health Information**

You have the right to request an amendment to your health information.
Your request must be in writing and must provide a reason for the amendment.
We may deny your request and, if so, you may submit a statement of disagreement.
However, we will make every attempt to honor your request.

- **Right to Request an Accounting of Disclosures of Your Health Information**

You have the right to request an accounting of our disclosures of your health information for purposes other than treatment, payment, and health care operations. We will make every attempt to honor your request. We are not required to provide an accounting for disclosures before April 14, 2003 or for more than 6 years prior to the date of your request.

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To exercise any of these rights please contact our Facility Privacy Officer.

Our Duties in Protecting Your Health Information

- We are required by law to maintain the privacy of your health information.
- We must inform residents or their legal representatives of our legal duties and privacy practices with respect to health information. This Notice discharges that duty.
- We must abide by the terms of the Notice currently in effect.
- We reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that we maintain. At any time, you may obtain a copy of the current notice from our Facility Privacy Officer.

Complaints, Contact Person, Effective Date, and Acknowledgement

- You may complain to us and to the Secretary of Health and Human Services if you believe your privacy rights have been violated.
 - You will not be retaliated against for filing a complaint.
 - You may file your complaint by contacting the Facility Privacy Officer or by writing or calling our Corporate Privacy Officer at:

Nexion Health, 6937 Warfield Ave., Sykesville, MD 21784, Attn: Corporate Privacy Officer, or by calling: 1-866-552-4800
 - You may file a complaint with the U.S. Secretary of Health and Human Services
 - For further information you may write or call our Corporate Privacy Officer.
 - This notice is effective April 14, 2003.
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Acknowledgment of Receipt of Notice

Resident name: _____ Medical Record Number _____

I have received a copy of the Facility's Notice of Privacy Practices.

Signature: _____ Date _____

If personal representative: Name: _____

Relationship to Resident: _____

Reason signature not obtained:

Resident too sick to sign at this time.

Resident would not sign.

Other: _____

Name of the Facility employee attempting unsuccessfully to obtain signature:

Date: _____
