

Our Lady of Lourdes Health Care Services, Inc. and Affiliates including
Our Lady of Lourdes Medical Center
Lourdes Medical Center of Burlington County
Administrative and General Policy

POLICY NUMBER: LHS AS0001PRI
NURSING CODE: _____
PAGE NUMBER: 1 of 39

TITLE: Patient Confidentiality and Uses/Disclosures of Protected Health Information: Master Policy

ACCOUNTABILITY:

President and Chief Executive Officer

OBJECTIVES:

RELATION TO MISSION:

Our Lady of Lourdes, a Catholic Health System – a member of Catholic Health East – dedicated to its Franciscan Tradition of serving all, will demonstrate the value of **Integrity** by fostering an ethical and moral environment where the behavior of associates/employees is positively impacted by adherence to the this policy.

RELATION TO OPERATION:

This policy provides guidance to all of Our Lady of Lourdes Health Care Services, Inc.'s and Affiliates' (OLLHCS, Inc.'s), trustees, officers, leadership associates, managers, supervisors, associates, employees, medical staff, house staff, contractors, volunteers, students and others and assists us in carrying out our daily activities within appropriate ethical and legal standards regarding patient privacy.

SOURCE: The Confidentiality and Privacy Policy, AS0059ADM is now incorporated into this policy.

I. PURPOSE:

To ensure the confidentiality of each patient's health information in compliance with federal and state laws.

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II. POLICY:

Our patients have entrusted their personal and clinical information to us. This information contains highly sensitive material and requires thoughtful and attentive management by those who have access to it. The entire workforce of OLLHCS, Inc. is committed to protecting our patients' right to privacy and safeguarding their protected health information.

A. Related Policies:

1. *Patient's Right to Access His or Her Own Protected Health Information, (OLLHCS, Inc. policy A0002PRI),*
2. *Documenting and Accounting for Disclosures of Protected Health Information, (OLLHCS, Inc. policy A0003PRI),*
3. *Disclosures of De-Identified Information and Limited Data Sets, (OLLHCS, Inc. policy A0004PRI),*
4. *Patient's Right to Amend Protected Health Information, (OLLHCS, Inc. policy A0005PRI),*
5. *Patient's Right to Request Restrictions on Uses and Disclosures of Protected Health Information, (OLLHCS, Inc. policy A0006PRI)*
6. *Patient's Right to Request Confidential Communications of Protected Health Information, (OLLHCS, Inc. policy A0007PRI),*
7. *Disclosure of Patient Information to Patient Directory, (OLLHCS, Inc. policy A0008PRI),*
8. *Training on HIPAA Policies and Procedures, (OLLHCS, Inc. policy A0009PRI),*
9. *Use and Disclosures of Protected Health Information for Marketing, (OLLHCS, Inc. policy A0010PRI),*
10. *Use and Disclosures of Protected Health Information for Fundraising, (OLLHCS, Inc. policy A0011PRI),*
11. *Mitigation of Use and Disclosure Violations, (OLLHCS, Inc. policy A0013PRI),*
12. *Authorization for Use and Disclosure of Psychotherapy Notes, (OLLHCS, Inc. policy A0014PRI),*
13. *Business Associate Agreement Policy, (OLLHCS, Inc. policy A0015PRI).*

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III. RESPONSIBLE PARTIES AND DUTIES:

A. Board of Trustees

OLLHCS, Inc.'s Board of Trustees will establish the privacy policies of OLLHCS, Inc. and assure adherence to such policies.

B. Privacy Officer

The Privacy Officer will develop policies and procedures to implement the privacy policies adopted by OLLHCS, Inc. and provide oversight over implementation of the policies to ensure compliance by OLLHCS, Inc.'s workforce.

The Privacy Officer is also responsible for the initial and on-going training of OLLHCS, Inc. associates/employees and other members of the workforce. The Privacy Officer will determine the scope of access to protected health information for each job position, define violations and infractions of the privacy policies and implement corrective actions for such violations and infractions.

C. Security Officer

The Security Officer is responsible for ensuring data security of OLLHCS, Inc.'s automated data, including maintenance of security passwords, restrictions of workforce member access to data files, and design of a system backup program to restore data in the event of loss and protecting the physical security of protected health information.

D. Workforce

OLLHCS, Inc.'s workforce members must respect the privacy of all patients, become informed and trained regarding all privacy policies, comply with OLLHCS, Inc. privacy policies and report any breach of such policies, whether the breach was committed by the individual or another member of the workforce. No member of the workforce can have access to protected health information until that member has agreed to adhere to the privacy policies of OLLHCS, Inc. and has signed a confidentiality statement. The term "workforce" means trustees, officers, leadership associates, managers, supervisors, associates, employees, medical staff, house staff, contractors, volunteers, students and others whose conduct, in the performance of work for OLLHCS, Inc., is under the direct control of OLLHCS, Inc.

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IV. Procedures:

A. Guiding Principles

1. Only permitted individuals can have access to use, or disclose protected health information. Permitted individuals are those whose job description or job responsibilities allow access to protected health information.
2. Permitted individuals may only use or disclose protected health information if there is appropriate patient authorization, (See Attachment D) or a legal exception permitting such use or disclosure.

B. Definitions

1. Disclosure means the release, transfer, provision of access to, or divulging in any other manner, of information outside OLLHCS, Inc.
2. Protected Health Information (PHI) means information relating to the health or condition of a patient, the provision of care to a patient, or the payment for the provision of health care to a patient that identifies the patient and is transmitted or maintained electronically or otherwise.
3. Use means the sharing, employment, application, utilization, examination, or analysis or information within OLLHCS, Inc.

C. Workforce Access Rights

1. Access rights to protected health information are limited to that which is necessary to adequately perform one's specific job responsibilities. *Access to a function on the computer does not imply that it is proper to search this information at will simply to satisfy curiosity.* Hard copy records are accessed by request to the department responsible for safeguarding the document and should be signed out appropriately.
2. Access rights to protected health information are defined in:
 - a) Associate/employee job descriptions
 - b) Contract terms or job descriptions for independent contractors;
or
 - c) Policies and procedures for hospital volunteers

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3. Persons not employed by OLLHCS, Inc. may have legitimate reasons to access patient information and/or information systems. Such access will be granted only when proper authorizations are in place. Such access will be time-limited. Non-associates / employees include, but are not limited to, Medical Staff members, students, employees of private medical staff contractors, consultants, volunteers, insurers, vendors and payer-based case managers.
4. OLLHCS, Inc. will make reasonable efforts to limit the amount of protected health information provided to members of the workforce who are permitted access to such information to ensure that only the minimum necessary is accessed to accomplish the intended purpose of the use or disclosure.

D. Patient Rights

1. OLLHCS, Inc.'s patients have the right to be informed of their rights to privacy regarding protected health information and OLLHCS, Inc.'s responsibilities to safeguard the confidentiality of a patient's protected health information. All patients will be provided with OLLHCS, Inc.'s Notice of Privacy Practices. (See Attachment A)
2. OLLHCS, Inc.'s patients have the right to restrict or amend their protected health information, have access to or obtain a copy of their information, obtain an accounting of the disclosures by OLLHCS, Inc. of their information and request communication of their protected health information by certain means. *See the following policies:*
 - a) *Patient's Right to Request Restrictions of Uses and Disclosures of Protected Health Information, (OLLHCS, Inc. policy A0006PRI)*
 - b) *Patient's Right to Amend Protected Health Information, (OLLHCS, Inc. policy A0005PRI)*
 - c) *Patient's Right to Access His/Her Own Protected Health Information, (OLLHCS, Inc. policy A0002PRI)*
 - d) *Documenting and Accounting of Disclosures of Protected Health Information. (OLLHCS, Inc. policy A0003PRI)*
3. The OLLHCS, Inc.'s Health Information Management Department (HIM) is responsible for handling any requests from patients to restrict the access to, or amend their protected health information, after consulting with OLLHCS, Inc. staff involved with the care of the patient.

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4. OLLHCS, Inc. staff members who receive requests from patients to restrict access to or amend their protected health information or receive communication of their protected health information by certain means should refer the patients and the requests to the OLLHCS, Inc.'s HIM.
5. OLLHCS, Inc. patients must authorize the use or disclosure of their protected health information for any purpose other than for treatment, payment or health care operations unless there is a legal exception that does not require an authorization by the patient. (See Attachment D)
See the following policies:
 - a) *Authorization for Use and Disclosure of Psychotherapy Notes; (OLLHCS, Inc. policy A0014PRI)*
 - b) *Use and Disclosure of Protected Health Information for Marketing; (OLLHCS, Inc. policy A0010PRI)*
 - c) *Use and Disclosure of Protected Health Information for Fundraising. (OLLHCS, Inc. policy A0011PRI)*
6. The following are examples of OLLHCS, Inc. payment, treatment or health care operations that are permitted.
 - a) Information accompanying a patient in a direct transfer from OLLHCS, Inc. to another facility.
 - b) Direct patient care.
 - c) Requests for information from the responsible practitioner in charge of the patient's care at OLLHCS, Inc.
 - d) Information to a referring physician regarding the specific service requested for the patient, the referring physician's note/report, lab, x-ray, etc.
 - e) Treatment information to a non-OLLHCS, Inc. physician.
 - f) Information pertaining to the injury and/or treatment for Workers' Compensation cases except patients with diagnoses of AIDS or HIV infection, alcohol or drug abuse, or mental illness.
 - g) Requests for information in an emergency situation if the disclosure is made in the "good faith belief that the use or disclosure is necessary to protect the health or safety of an individual from serious, imminent harm." When this type of release is made an entry regarding the nature of the release must be documented in the medical record.

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- h) Requests by the accrediting and licensing bodies (JCAHO, Department of Health) (with appropriate identification) to review medical records during surveys for accreditation and State licensure or as otherwise required by law.
- i) Requests by committees of the Medical Staff conducting reviews of quality of care.
- j) Requests from authorized Federal and State insurance programs/review organizations or other authorized agencies (e.g., Medicare, Peer Review Organization).
- k) Paying physicians, hospitals and others who provide health care services to the patient.
- l) Providing payment information about a patient to another health care provider for their payment activities relating to the patient.
- m) Performing case management, utilization review, and risk assessments.
- n) Performing accreditation, licensing or credentialing activity.
- o) Analyzing health plan claims or health care record data.
- p) Conducting quality assurance activities or outcomes assessments.

E. Patient Acknowledgement Required for Receipt of Notice of Privacy Practices

1. OLLHCS, Inc. must provide each patient with OLLHCS, Inc.'s Notice of Privacy Practices (See Attachment A) no later than the date of the first service delivery, including service delivered electronically. ***EXCEPT*** in emergency treatment situations. OLLHCS, Inc. must provide the Notice as soon as reasonably practicable after the delivery of the emergency treatment.
2. The Admissions Department of OLLHCS, Inc. is responsible, at the time of an inpatient or outpatient admission, for assuring that each patient:
 - a) receives or has already received a copy of the Notice of Privacy Practices, and
 - b) signs a written acknowledgement of receipt of the Notice.
3. If a patient's acknowledgement of receipt is not obtained, Admissions Department personnel must document their good faith efforts to obtain the acknowledgement and the reason why the acknowledgement was not obtained.
4. The Admissions Department also is responsible for documenting that the patient received or had the opportunity to receive the Notice of Privacy

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Practices in writing and signed the acknowledgement indicating receipt of the Notice.

5. OLLHCS, Inc. must post its Notice of Privacy Practices in a clear and prominent location where it is reasonable to expect individuals seeking treatment from OLLHCS, Inc. to be able to read the Notice.
6. Whenever the Notice is revised, OLLHCS, Inc. must make the Notice available upon request on or after the effective date of the revision and provide the revised Notice to patients as described above.
7. Since OLLHCS, Inc. maintains a website that provides information about its services, the Notice Privacy Practices will be prominently displayed on the website. In addition, OLLHCS, Inc. must make the Notice available to its patients electronically.

F. Use or Disclose Only the Minimum Necessary

1. Minimum necessary applies. This requirement applies when OLLHCS, Inc. itself uses or discloses protected health information for a purpose other than treatment or when OLLHCS, Inc. requests protected health information from another entity for payment or health care operations.
2. Minimum necessary does not apply. This requirement does not apply to:
 - a) Disclosures to or requests by another health care provider for treatment;
 - b) Uses or disclosures made to the patient;
 - c) Uses and disclosures made pursuant to a patient's authorization;
 - d) Disclosures made to the Secretary of Health and Human Services; or
 - e) Uses or disclosures that are required by law.
3. When minimum necessary applies, the work force of OLLHCS, Inc. should limit any request for protected health information to that which is reasonably necessary to accomplish the purpose for which the request is made.
 - a) For a request that is made on a routine and recurring basis. OLLHCS, Inc. will implement policies and procedures that limit the protected health information requested to the amount reasonably necessary to accomplish the purpose for which the request is made.
 - b) In all other requests, OLLHCS, Inc. will review the request on case-by-case basis to determine that the protected health

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information sought is limited to the information reasonably necessary to accomplish the purpose for which the request is made.

- c) For all uses, disclosures, or requests to which the requirements apply, OLLHCS, Inc. may not use, disclose or request an entire medical record, except when the entire medical record is specifically justified as the amount that is reasonably necessary to accomplish the purpose of the use, disclosure, or request.

G. Use and Disclosure for which Patient Authorization is Required

1. Use or disclosure of psychotherapy notes except in certain circumstances [See Policy on *Authorization for Use or Disclosure of Psychotherapy Notes*, (OLLHCS, Inc. policy A0014PRI)]
2. Research [See Policy on *Use and Disclosure of Protected Health Information for Research* (OLLHCS, Inc. policy A0012PRI)]
3. Disclosure to third parties outside OLLHCS, Inc. for purposes other than treatment, payment or health care operations. [See *Policies on Use and Disclosures of Protected Health Information for Marketing*(OLLHCS, Inc. policy A0010PRI) and *Use and Disclosures of Protected Health Information for Fundraising*(OLLHCS, Inc. policy A0011PRI)]
4. HIM associates/employees are responsible for obtaining the signed “Authorization For Use/Disclosure of Protected Health Information” form (See Attachment D) from the patient whenever a request for PHI is made that is not for any purpose other than for treatment, payment or health care operations
5. Patients also have a right to revoke, for any reason, the above named “Authorization” by submitting a “Revocation of Authorization For Disclosure of Health Information” form. (See Attachment E)

H. Use and Disclosure Permitted by Law without Patient Authorization

1. Requests for pertinent information from the police in cases involving knife wounds, bullet wounds, gunshot wounds, powder burns, or any injury that would seriously maim, produce death, or render unconscious, caused by the use of violence or sustained in a suspicious or unusual manner.
2. Reporting information about victims of abuse, neglect or domestic violence if we believe in our professional judgment, it is necessary to prevent serious

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harm to the patient or other potential victims or if disclosure is expressly authorized by statute or regulation.

3. In compliance with and as limited by the relevant requirements of:
 - a) A court order or court-ordered warrant, or a subpoena or summons issued by a judicial officer;
 - b) A grand jury subpoena; or
 - c) An administrative request, including an administrative subpoena or summons, a civil or an authorized investigative demand, or similar process authorized under law, provided that:
 - (1) The information sought is relevant and material to a legitimate law enforcement inquiry;
 - (2) The request is specific and limited in scope to the extent reasonably practicable in light of the purpose for which the information is sought; and
 - (3) De-identified information could not reasonably be used.
4. OLLHCS, Inc. may disclose protected health information in response to law enforcement official's request for information to identify or locate a suspect, fugitive, material witness or missing person.
 - a) OLLHCS, Inc. may disclose only the following information:
 - (1) Name and address;
 - (2) Date and place of birth;
 - (3) Social Security number;
 - (4) ABO blood type and RH factor;
 - (5) Type of injury;
 - (6) Date and time of treatment;
 - (7) Date and time of death, if applicable; and
 - (8) A description of distinguishing physical characteristics, including height, weight, gender, race, hair and eye color, presence or absence of facial hair (beard or moustache), scars, and tattoos.
5. Reporting victims of a crime, if:
 - a) The individual agrees to the disclosure; or
 - b) OLLHCS, Inc. is unable to obtain the individual's agreement because of incapacity or other emergency circumstance, provided that:

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- (1) The law enforcement official represents that such information is needed to determine whether a violation of law by a person other than the victim has occurred, and such information is not intended to be used against the victim;
 - (2) The law enforcement official represents that immediate law enforcement activity that depends upon the disclosure would be materially and adversely affected by waiting until the individual is able to agree to the disclosure; and
 - (3) The disclosure is in the best interests of the individual as determined by OLLHCS, Inc., in the exercise of professional judgment.
6. Alerting law enforcement of the death of the individual if OLLHCS, Inc. has a suspicion that such death may have resulted from criminal conduct.
7. Providing evidence of criminal conduct that occurred on the premises of OLLHCS, Inc.
8. When providing emergency health care other than on the premises of OLLHCS, Inc., to alert law enforcement to:
 - a) The commission and nature of a crime;
 - b) The location of such crime or of the victim(s) of such crime; and
 - c) The identity, description, and location of the perpetrator of such crime.
9. Requests from the Medical Examiner or his/her deputy, the Coroner or his/her deputy, or their respective appointees, relating to the investigation of a death and/or the determination of a cause of death (not necessarily that of a OLLHCS, Inc. patient) which includes patients with AIDS or HIV infection, alcohol/drug abuse and mental illness (with appropriate identification and documentation).
10. Identification of deceased individuals.
11. Using or disclosing protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

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12. Requests from the New Jersey Department of Health and Senior Services or other person authorized by law, regarding mandatory reporting of infectious and communicable diseases or for use in the following:
 - a) Disease or injury report
 - b) Public Health surveillance
 - c) Public Health investigation or intervention
 - d) Health or disease registry
13. Disclosures to law enforcement authorities to identify or apprehend an individual;
 - a) Because of a statement by an individual admitting participation in a violent crime that OLLHCS, Inc. reasonably believes may have caused serious physical harm to the victim; or
 - b) Where it appears from all the circumstances that the individual has escaped from a correctional institution or from lawful custody.

I. Situations Where a Personal Representative May Act for a Patient Regarding Protected Health Information

1. Any individual who, acting alone can obtain a type of health care without violating any applicable Federal or State law, and who has sought this care, can authorize the use and release of his or her health information.
2. If under applicable law a person has authority to act on behalf of an individual who is an adult or an emancipated minor in making decisions related to health care, OLLHCS, Inc. must treat such person as a personal representative. A person holding authority under a valid Durable Power of Attorney, for Health Care Decisions falls within this category.
3. Health care information may be released to a patient's personal representative or relative for the purpose of providing health care to the patient if:
 - a) The patient has been notified of his/her right to object to the disclosure and the patient has not objected to the disclosure; or
 - b) The patient is in a physical or mental condition such that the individual is not capable of objecting, and there are no prior indications that the individual would object.
4. If under applicable law a parent, guardian, or other person acting *in loco parentis* has authority to act on behalf of an individual who is an unemancipated minor in making decisions related to health care, OLLHCS,

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Inc. must treat such person as a personal representative. The following conditions apply:

- a) If the minor consents to such health care service; then no other consent is required, and the minor has not requested that such person be treated as the personal representative;
 - b) The minor may lawfully obtain such health care service without the consent of a parent, guardian, or other person acting *in loco parentis*, and the minor, a court, or another person authorized by law consents to such health care service; or
 - c) A parent, guardian or other person acting *in loco parentis* assents to an agreement of confidentiality between a covered health care provider and the minor with respect to such health care service.
5. Deceased Individuals: If under applicable law an executor, administrator, or other person has authority to act on behalf of a deceased individual or of the individual's estate, OLLHCS, Inc. must treat such person as a personal representative.
6. Cases or suspected cases of abuse, neglect, or endangerment. Unless there is a conflict in an existing State law, OLLHCS, Inc. may decide not to treat a person as the personal representative of patient if there is a reasonable belief that:
- a) The patient has been or may be subjected to domestic violence, abuse, or neglect by such person; or
 - b) Treating such person as the personal representative could endanger the patient and OLLHCS, Inc., in the exercise of professional judgment, OLLHCS, Inc. determines that it is not in the best interest of the patient to treat the person as the individual's personal representative.

J. Verification Requirements for Disclosure of Protected Health Information

1. OLLHCS, Inc. is required by Federal and State laws to verify the identity of a person requesting protected health information and the authority of that person to have access to protected health information, if the identity or authority of the person is not known to OLLHCS, Inc.
2. Prior to any disclosure of protected health information, the appropriate personnel must obtain any documentation, statements, or representations, whether oral or written, from the person requesting the protected health

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information, when such documentation, statement or representation is a condition of disclosure as set forth in OLLHCS, Inc. policies and procedures. OLLHCS, Inc. may rely on documentation, statements, or representations that, on their face, meet the applicable requirements so long as such reliance is reasonable under the circumstances.

3. OLLHCS, Inc. may rely, if the reliance is reasonable under the circumstances, on any of the following to verify identity when the disclosure of protected health information is to a public official or person acting on behalf of a public official:
 - a) If the request is made in person, presentation of an agency identification badge, other official credentials, or other proof of government status;
 - b) If the request is in writing, the request is on the appropriate government letterhead; or
 - c) If the disclosure is to a person acting on behalf of a public official, a written statement on appropriate government letterhead that the person is acting under the government's authority or other evidence or documentation of agency, such as a contract for services, memorandum of understanding, or purchase order, that establishes that the person is acting on behalf of the public official.
4. OLLHCS, Inc. may rely, if the reliance is reasonable under the circumstances, on any of the following to verify authority when the disclosure of protected health information is to a public official or a person acting on behalf of the public official:
 - a) A written statement of the legal authority under which the information is requested, or, if a written statement would be impracticable, an oral statement of such legal authority; or
 - b) If a request is made pursuant to legal process, warrant, subpoena, order or other legal process issued by a grand jury or a judicial or administrative tribunal is presumed to constitute legal authority.
5. OLLHCS, Inc. personnel will meet the verification requirements of this policy if they use their professional judgment when making a use or disclosure for OLLHCS, Inc.'s patient directory, in emergency circumstances, for a family

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member's or close friend's involvement in the patient's care, for notification purposes, or for disaster relief purposes.

6. OLLHCS, Inc. personnel will meet the verification requirements of this policy if they act on a good faith belief in making a disclosure to avert a serious threat to health or safety.

V. CONFIDENTIALTY AND PRIVACY DURING TREATMENT AND CARE OF THE PATIENT

Confidential information including requests for financial and health data obtained from the patient/family at various points of service are to be obtained discreetly in a manner that provides both visual and auditory privacy.

A patient has the right to every consideration of their privacy concerning their medical treatment, including confidentiality that the individual is a patient. Case discussion, consultation and/or clinical/laboratory results are to be conducted in appropriate settings with vocal tones that ensure auditory privacy. Patient-related information is confidential and should not be discussed in elevators, hallways, cafeteria and other public places.

The patient's privacy and dignity are to be maintained during transport to internal and external facilities. Proper clothing and draping of the patient are to be ensured during treatment, testing and/or transport, while in his/her room and on the nursing unit.

All patient rooms are to be entered with special consideration to patient's privacy. Any signage or Medical Records posted at the patient's bedside are to be approved by OLLHCS, Inc. policy and used with discretion. Bedside curtains are to be drawn when discussing information with patients, conducting physical examinations and/or providing treatment/care.

Patient's privacy for hygiene needs includes instruction in the use of the privacy lock, (if clinically appropriate) or drawing curtains around bedside. All associates/employees are to knock before entering the patient's room, announce his/her name and the purpose for the visit to ensure the patient's right to privacy.

VI. RESPONSIBILITY:

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Responsibility for the content and administration of this policy resides with the OLLHCS, Inc. Board of Trustees.

ENFORCEMENT:

Violation of patient confidentiality policies will be grounds for disciplinary action, up to and including termination. In addition, persons violating patient confidentiality practices may be subject to civil and criminal liability under applicable law.

APPROVED BY: _____
Alexander J. Hatala, President and Chief Executive Officer

ORIGINAL AND REVISION DATES: 02/03/03; 11/24/04;
11/30/07, 11/30/10

NEW EFFECTIVE DATE 09/30/12

REQUIRES REAUTHORIZATION IN: 09/30/15

AS0001PRI
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Attachment A

OUR LADY OF LOURDES HEALTH CARE SERVICES, INC.

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**

Effective Date: _____

If you have any questions about this notice, please contact the Hospital's Privacy Officer.

Our Lady of Lourdes Health System

1600 Haddon Avenue
Risk/Compliance
Camden, NJ 08103
Telephone number: 856-757-3921

WHO WILL FOLLOW THIS NOTICE

This notice describes our hospital's practices and those of:

- Any healthcare professional authorized to enter information into your hospital medical record.
- All departments and units of the hospital.
- Any member of a volunteer group we allow to help you while you are in the hospital.
- All associates/employees, staff and other hospital personnel.

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- All these persons, entities, sites, and locations follow the terms of this notice. In addition, these persons, entities, sites, and locations may share medical information with each other for treatment, payment, or hospital operations purposes as described in this notice.

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at the hospital. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the hospital, whether made by hospital personnel or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office or clinic.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- Make sure that medical information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of these categories.

- **For Treatment.** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you at the hospital. For example, a doctor treating you for a broken hip may need to know if

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you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can arrange for appropriate meals. We also may disclose medical information about you to people outside the hospital who may be involved in your medical care after you leave the hospital, such as family members, clergy, or others we use to provide services that are part of your care, such as therapists or physicians.

- **For Payment.** We may use and disclose medical information about you so that the treatment and services you receive at the hospital may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about treatment you received at the hospital so your health plan will pay us or reimburse you for the treatment. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. We also may disclose information about you to another health care provider, such as another hospital, for their payment activities concerning you.
- **For Healthcare Operations.** We may use and disclose medical information about you for hospital operations. These uses and disclosures are necessary to run the hospital and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many hospital patients to decide what additional services the hospital should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students and other hospital personnel for review and learning purposes. We may also combine the medical information we have with medical information from other hospitals to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and healthcare delivery without learning the identities of specific patients. We also may disclose information about you for another hospital's health care operations if you also have received care at that hospital.
- **Treatment Alternatives.** We may use and disclose medical information to tell you about or recommend different ways to treat you.

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- **Health-Related Benefits and Services.** We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.
- **Fundraising Activities.** We may use medical information about you to contact you in an effort to raise money for the hospital and its operations. We may disclose medical information to a business partner or a foundation related to the hospital so that the business partner or the foundation may contact you in raising money for the hospital. We only would release contact information, such as your first and last name, address and telephone number, and the dates you received treatment or services at the hospital.

If you do not want the hospital to contact you for fundraising efforts, you must notify the hospital's Privacy Officer in writing.

- **Hospital Directory.** Unless you tell us otherwise, we may include certain limited information about you in the hospital directory while you are a patient at the hospital. This information may include your name, location in the hospital, your general condition (e.g., fair, stable, etc.) and your religious affiliation. The directory information, except for your religious affiliation, may also be released to people who ask for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or rabbi, even if they do not ask for you by name. This is so your family, friends and clergy can visit you in the hospital and generally know how you are doing. If you do not want anyone to know this information about you, if you want to limit the amount of information that is disclosed, or if you want to limit who gets this information, you must notify the hospital's Privacy Officer in writing or indicate your preference on the Hospital's Patient Directory Instructions Form that you will receive when you are registered.
- **Individuals Involved in Your Care or Payment for Your Care.** We may release medical information about you to a friend or family member who is involved in your medical care. This would include persons named in any durable health care power of attorney or similar document provided to us. We may also give information to someone who helps pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location. You can object to these releases by telling us that you do not wish any or all individuals involved in your care to receive this information. If you are not present or cannot agree or object, we will use our professional judgment to decide whether it is in your best

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interest to release relevant information to someone who is involved in your care or to an entity assisting in a disaster relief effort.

- **Research.** Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process. We may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave the hospital. We will almost always ask for your specific permission if the researcher will have access to your name, address, or other information that reveals who you are, or will be involved in your care at the hospital.
- **As Required By Law.** We will disclose medical information about you when required to do so by federal, state, or local law.
- **To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

SPECIAL SITUATIONS

- **Organ and Tissue Donation.** If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation, or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.
- **Military and Veterans.** If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority. We may use and disclose to components of the Department of Veterans Affairs medical information about you to determine whether you are eligible for certain benefits.

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- **Workers' Compensation.** We may release medical information about you for Workers' Compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Public Health Risks.** We may disclose medical information about you for public health activities. These activities generally include the following:
 - To prevent or control disease, injury, or disability;
 - To report deaths;
 - To report reactions to medications or problems with products; to notify people of recalls of products they may be using;
 - To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and
 - To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- **Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the healthcare system, government programs and compliance with civil rights laws.
- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- **Law Enforcement.** We may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons, or similar process;

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- To identify or locate a suspect, fugitive, material witness, or missing person;
 - About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
 - About a death we believe may be the result of criminal conduct;
 - About criminal conduct at the hospital; and
 - In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description, or location of the person who committed the crime.
- **Coroners, Medical Examiners, and Funeral Directors.** We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about deceased patients of the hospital to funeral directors as necessary to carry out their duties upon the request of the patient's family.
- **National Security and Intelligence Activities.** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- **Protective Services for the President and Others.** We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.
- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; (3) for the safety and security of the correctional institution; or (4) to obtain payment for services provided to you.

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YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information we maintain about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes and other mental health records under certain circumstances.

To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Hospital's Health Information Management Department. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request. If you agree, we may provide you with a summary of the information instead of providing you with access to it, or with an explanation of the information instead of a copy. Before providing you with such a summary or explanation, we first will obtain your agreement to pay the fees, if any, for preparing the summary or explanation.

We may deny your request to inspect and copy your medical information in certain very limited circumstances, such as when your physician determines that for medical reasons this is not advisable. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed healthcare professional chosen by the hospital will review your request and the denial. The person conducting the review will not be the person who denied your request. We will do what this person decides.

- **Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the hospital.

To request an amendment, your request must be made in writing and submitted to the Hospital's Privacy Officer. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

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- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for the hospital;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

- **Right to an Accounting of Disclosures.** You have the right to request an “accounting of disclosures.” This is a list of some of the disclosures we made of medical information about you that were not specifically authorized by you in advance.

To request this list or accounting of disclosures, you must submit your request in writing to the Hospital’s Health Information Management Department. Your request must state a time period that may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example: on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or healthcare operations. You also have the right to request a limitation on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to the Hospital’s Privacy Officer. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

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- **Right to Confidential Communications.** You have the right to request to receive communications from us on a confidential basis by using alternative means for receipt of information or by receiving the information at alternative locations. For example, you can ask that we only contact you at work or by mail, or at another mailing address, besides your home address. We must accommodate your request, if it is reasonable. You are not required to provide us with an explanation as to the reason for your request. Contact the Privacy Officer if you require such confidential communications.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

To obtain a paper copy of this notice, request a copy from the Hospital's Privacy Officer in writing.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the hospital. The notice will contain on the first page, in the top right-hand corner, the effective date. [In addition, each time you register at or are admitted to the hospital for treatment or healthcare services as an inpatient or outpatient, we will offer you a copy of the current notice in effect.]

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the hospital or with the Secretary of the Department of Health and Human Services. To file a complaint with the hospital, contact John P. McGrenra, Jr., Privacy Officer, 1600 Haddon Avenue, Camden, NJ 08103. Telephone Number 856-757-3921. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use

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or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission and that we are required to retain our records of the care that we provided to you.

AC0001PRI
Master Policy On Uses and Disclosures of Protected Health Information

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Our Lady of Lourdes Health Care Services, Inc. and Affiliates including
Our Lady of Lourdes Medical Center
Lourdes Medical Center of Burlington County
Administrative and General Policy

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Our Lady of Lourdes Health Care Services, Inc.

PATIENT ACKNOWLEDGMENT

I have been given a copy of Our Lady of Lourdes Health Care Services, Inc.'s Notice of Privacy Practices, version effective _____.

Signature of Patient or Representative

Date

Print Name

Relationship of Representative to Patient

Please describe the Representative's authority to act on behalf of Patient: _____

FOR OUR LADY OF LOURDES HEALTH CARE SERVICES, INC. USE ONLY

If acknowledgment of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain their acknowledgment and the reason you could not obtain it:

NOTE: ANY PRINTED COPY OF THIS POLICY IS ONLY AS CURRENT AS OF THE DATE IT WAS PRINTED; IT MAY NOT REFLECT SUBSEQUENT REVISIONS. REFER TO THE ON-LINE VERSION FOR THE MOST CURRENT POLICY. USE OF THIS DOCUMENT IS LIMITED TO LOURDES HEALTH SYSTEM STAFF ONLY. IT IS NOT TO BE COPIED OR DISTRIBUTED OUTSIDE THE INSTITUTION WITHOUT ADMINISTRATIVE PERMISSION.

Our Lady of Lourdes Health Care Services, Inc. and Affiliates

POLICY NUMBER: LHS AS0001PRI

NURSING CODE: _____

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NOTE: ANY PRINTED COPY OF THIS POLICY IS ONLY AS CURRENT AS OF THE DATE IT WAS PRINTED; IT MAY NOT REFLECT SUBSEQUENT REVISIONS. REFER TO THE ON-LINE VERSION FOR THE MOST CURRENT POLICY. USE OF THIS DOCUMENT IS LIMITED TO LOURDES HEALTH SYSTEM STAFF ONLY. IT IS NOT TO BE COPIED OR DISTRIBUTED OUTSIDE THE INSTITUTION WITHOUT ADMINISTRATIVE PERMISSION.

Our Lady of Lourdes Health Care Services, Inc. and Affiliates

POLICY NUMBER: A0001PRI
NURSING CODE: _____
PAGE NUMBER: 30

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Attachment B

Our Lady of Lourdes Health Care Services, Inc.

PATIENT DIRECTORY INSTRUCTIONS

I do _____/do not _____ consent to the disclosure of my name, location, general condition and religious affiliation to anyone who may inquire about me. I understand that if I do not consent to this disclosure, visitors such as family and friends, outside telephone callers, florists and members of the clergy will not be able to contact me.

Signature of Patient or Representative

Date

Time AM / PM

Print Name

Relationship of Representative to Patient

Please describe the Representative's authority to act on behalf of the Patient:

Our Lady of Lourdes Health Care Services, Inc. and Affiliates

POLICY NUMBER: A0001PRI

NURSING CODE: _____

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Attachment C

Our Lady of Lourdes Health Care Services, Inc.

MEDICAL RECORD CHECKLIST
[For use inside cover of medical record]

1. Patient signed acknowledgement of receipt of Notice of Privacy Practices?
_____ Yes _____ No _____ Date
2. Any restrictions on use and disclosure of medical information?
_____ Yes _____ No _____ Date

Brief summary of restrictions:

3. Any restrictions on means of communication? _____ Yes _____ No

Brief summary of restrictions:

4. Consent to directory listing _____ Yes _____ No
5. Consent to clergy notification _____ Yes _____ No
6. Names of family members or significant others authorized to receive PHI

Our Lady of Lourdes Health Care Services, Inc. and Affiliates

POLICY NUMBER: A0001PRI
NURSING CODE: _____
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Attachment D

Our Lady of Lourdes Health Care Services, Inc.
AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

I authorize Our Lady of Lourdes Health Care Services, Inc. to disclose the following information from the medical records of:

Patient Name: _____ Date of birth: _____

Address: _____

Telephone: _____ Patient Number _____

Covering the period(s) of health care:

From _____ to _____
From _____ to _____

Information to be disclosed:

- Complete health record(s), including all images (x-rays, photographs, etc.)
- Complete health record(s), excluding all images

OR

Select from the following (check as many as apply):

- Discharge Summary
- History and Physical Examination
- Consultation Reports
- AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection
- Mental health care or services
- Psychotherapy Notes
- Treatment for alcohol and/or drug abuse
- Photographs, videotapes, digital or other images
- Other (please specify) _____
- Progress Notes
- Laboratory Tests
- X-ray reports

Our Lady of Lourdes Health Care Services, Inc. and Affiliates

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This information is to be disclosed to the following individual or entity for the purpose of:

Name: _____ Relationship: _____

Address: _____

Telephone: _____

Attachment D (cont.)

The patient or the patient's representative must read and initial the following statements:

- a. I understand that unless earlier revoked, this authorization will expire on __/__/__ or on the happening of _____.
Initials: _____
- b. I understand that I may revoke this authorization at any time by notifying the Hospital in writing, but if I do it won't have any effect on any actions the Hospital took before it received the revocation. Initials: _____
- c. I understand that the Hospital cannot make me sign this authorization as a condition to receive treatment from the Hospital except:
- (i) when the Hospital provides me with research-related treatment; or
 - (ii) when the Hospital provides me with health care solely for the purpose of creating protected health information for disclosure to someone else.
Initials: _____

Our Lady of Lourdes Health Care Services, Inc., its associates/employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

(Form MUST be completed before signing)

Signature of Patient or Representative

Our Lady of Lourdes Health Care Services, Inc. and Affiliates

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Date

Print Name

Relationship of Representative to Patient

Please describe the Representative's authority to act on behalf of the Patient:

****YOU MAY REFUSE TO SIGN THIS AUTHORIZATION****

You may not use this form to release information for treatment or payment except when the information to be released is psychotherapy notes or certain research information.

Our Lady of Lourdes Health Care Services, Inc. and Affiliates

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Attachment –D - Spanish Version

Our Lady of Lourdes Health Care Services, Inc.
AUTORIZACIÓN PARA EL USO/DIVULGACIÓN DE LA INFORMACIÓN MÉDICA
PROTEGIDA

Por la presente, autorizo el uso o divulgación de mi información médica singularizable, según se describe más adelante. Entiendo que esta autorización es voluntaria. Entiendo que si la organización autorizada a recibir la información no es un plan médico ni un proveedor de atención médica, la información divulgada ya no estaría protegida por las regulaciones federales. ♦♦♦

Yo autorizo a *Our Lady of Lourdes Health Care Services, Inc.* a divulgar la siguiente información extraída de los archivos médicos de:

Nombre del paciente: _____ Fecha de nacimiento: _____

Dirección: _____

Teléfono: _____ Número del paciente _____

Periodo(s) de atención médica cubierto:

De _____ a _____
• De _____ a _____

Información que podrá revelarse:

- Archivo(s) médico(s) completo(s), incluidas todas las imágenes (rayos X, fotografías, etc.)
- Archivo(s) médico(s) completo(s), excepto las imágenes
- O

Seleccione entre los siguientes (marque todos los que correspondan):

- Informe de alta
- Antecedentes y exploración física
- Partes de interconsulta
- Infección con SIDA (Síndrome de inmunodeficiencia adquirida) o VIH (Virus de la Inmunodeficiencia Humana)
- Servicio o atención psiquiátricos
- Comentarios de psicoterapia
- Tratamiento por abuso de alcohol y/o drogas
- Fotografías, videocintas, imágenes digitales u otras imágenes
- Comentarios de evolución
- Pruebas de laboratorio
- Informes de rayos X

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Otro (por favor, especifique)

Esta información deberá revelarse a los siguientes individuos o entidades con el propósito de:

Nombre: _____ Relación: _____

Dirección: _____

Teléfono: _____

El paciente o el representante del paciente deberá leer y escribir sus iniciales al lado de las siguientes afirmaciones:

d. Entiendo que a menos que se revoque con anterioridad, esta autorización caducará el ___/___/___ o al suceder lo siguiente

_____ Iniciales: _____

e. Entiendo que puedo revocar esta autorización en cualquier momento comunicándoselo al Hospital por escrito, pero si lo hago, ello no influirá en ninguna medida que haya tomado el Hospital antes de recibir esta revocación. Iniciales: _____

f. Entiendo que el Hospital no puede hacerme firmar esta autorización como condición para recibir tratamiento en el Hospital, excepto:

(i) si el Hospital me brinda un tratamiento relacionado con una investigación; o

(ii) si el Hospital me brinda atención médica con el único propósito de crear información médica protegida para revelársela a terceros.

Iniciales: _____

Our Lady of Lourdes Health Care Services, Inc., sus asociados/empleados, funcionarios y médicos quedan exentos por la presente de cualquier responsabilidad legal o civil por divulgar la información referida anteriormente en la medida en que se indica y autoriza aquí.

(El formulario TIENE que ser llenado antes de firmarlo)

Firma del paciente o del representante

Our Lady of Lourdes Health Care Services, Inc. and Affiliates

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Fecha

Nombre en letra de molde

Relación del representante con el paciente

Por favor, describa la autoridad del representante para tomar decisiones en nombre del paciente:

Our Lady of Lourdes Health Care Services, Inc. and Affiliates

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****USTED PUEDE NEGARSE A FIRMAR ESTA AUTORIZACIÓN****

Usted no deberá usar este formulario para revelar información para un tratamiento o pago, excepto cuando la información que se vaya a revelar sean comentarios de psicoterapia o cierta información investigativa.

◆◆◆ AVISO AL DESTINATARIO DE LA INFORMACIÓN

La información aquí mencionada que se le va a revelar puede provenir de archivos cuya confidencialidad esté protegida por las leyes federales. Las Regulaciones Federales (45 CFR Partes 160 a la 164 y 42 CFR-Parte 2) le prohíben que usted revele a su vez esta información sin el consentimiento específico de la persona a la que pertenece esta información o, lo que de otro modo esté permitido por dichas regulaciones. Una Autorización General para divulgar información médica o de otra naturaleza NO es suficiente para este fin. Las leyes federales limitan el uso de la información para una investigación delictiva o para enjuiciar a un paciente por abuso de drogas o de alcohol.

Our Lady of Lourdes Health Care Services, Inc. and Affiliates

POLICY NUMBER: A0001PRI
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Attachment E

Our Lady of Lourdes Health Care Services, Inc.

**REVOCATION OF AUTHORIZATION FOR DISCLOSURE
OF HEALTH INFORMATION**

1. I hereby revoke my previous authorization(s) to Our Lady of Lourdes Health Care Services, Inc. to disclose information from the health records of:

Patient name _____ Date of birth _____
Address _____ Telephone _____
Patient number _____
Prior Authorization(s):
Dated: _____ Recipient: _____
Dated: _____ Recipient: _____
Dated: _____ Recipient: _____

2. I request to **revoke** my authorization to release the following information:

- ALL** protected health information
- HIV Test results Acquired immuno deficiency syndrome (AIDS)
- Treatment for alcohol and/or drug abuse Sexually-Transmitted Diseases
- Psychotherapy Notes (from the records of my treatment by a psychiatrist, licensed psychologist or psychiatric clinical nurse specialist)
- Other (please specify) _____

3. I understand that disclosures made in good faith may have already occurred in reliance upon my previously issued authorization and that this revocation cannot apply retroactively to such disclosures. I also understand that the disclosure of health information may be required by law in some instances, such as for the reporting of communicable diseases.

4. Our Lady of Lourdes Health Care Services, Inc., its associates/employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the information I authorized previously.

Signature of Patient or Authorized Party

Date

Printed Name

Relationship to Patient