NOTICE OF PRIVACY PRACTICES
OF THE
SYCAMORE FIRE DEPARTMENT

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.

If you have any questions about this notice, please contact the Privacy Officer of the Sycamore Fire Department at 815-895-4514, 535 DeKalb Avenue, Sycamore IL 60178.

WHO WILL FOLLOW THIS NOTICE
This notice describes the information privacy practices followed by our employees, staff and other office personnel.

YOUR HEALTH INFORMATION
This notice applies to the information and records we have about your health, health status, and the health care and service you receive by our City. We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU
For Treatment: We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health. For example, this includes such things as verbal and written information that we obtain about you and use pertaining to your medical condition and treatment provided to you by us and other medical personnel (including doctors and nurses who give orders to allow us to provide treatment to you). It also includes information we give to other health care personnel to whom we transfer your care and treatment, and includes transfer of PHI via radio or telephone to the hospital or dispatch center as well as providing the hospital with a copy of the written record we create in the course of providing you with treatment and transport. Different personnel in our department may share information about you and disclose information to people who do not work in our office in order to coordinate your care. Family members and other health care providers may be part of your medical care outside this department and may require information about you that we have.

For Payment: We may use and disclose health information about you so that the treatment and services you receive from the Sycamore Fire Department 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 a service you received here so your health plan will pay us or reimburse you for the service.

For Health Care Operations: We may use and disclose health information about you in order to make sure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

Treatment Alternatives: We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

SPECIAL SITUATIONS
We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

To Avert a Serious Threat to Health or Safety: We may use and disclose health 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.

Required by Law: We will disclose health information about you when required to do so by federal, state or local law.

Research: We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in you care at the office.

Organ and Tissue Donation: If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

Military, Veterans, National Security and Intelligence: If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation: We may release health 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 health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Health Oversight Activities: We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care 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 health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

Law Enforcement: We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

Coroners, Medical Examiners and Funeral Directors: We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

Information Not Personally Identifiable: We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Family and Friends: We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization*. We must obtain your *Authorization* separate from any Consent we may have obtained from you. If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization*, in writing, at any time. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission.

The following uses and disclosures of medical information about you will only be made with your authorization (signed permission): Uses and disclosures for marketing purposes; Uses and disclosures that constitute the sales of medical information about you; Most uses and disclosures of psychotherapy notes, if we maintain psychotherapy notes; and Any other uses and disclosures not described in this Notice.

If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization (different than the *Authorization* and *Consent* mentioned above) from you. In order to disclose these types of records for purposes of treatment, payment or health care operations, we will have to have both your signed *Consent* and a special written *Authorization* that complies with the law governing HIV or substance abuse records.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

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

Right to Inspect and Copy: You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to the Privacy Officer in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to Amend: If you believe the health 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 as long as the information is kept by this office. To request an amendment, complete and submit a Medical Record Amendment/Correction Form to the Privacy Officer.

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:

a) We did not create, unless the person or entity that created the information is no longer available to make the amendment.
b) Is not part of the health information that we keep.
c) You would not be permitted to inspect and copy.
d) 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 the disclosures we made of medical information about you for purposes other than treatment, payment and health care operations. To obtain this list, you must submit your request in writing to the Privacy Officer. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. 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 that we limit the use and disclosure of medical information about you for treatment, payment and healthcare operations.

Under federal law, we must agree to your request and comply with your requested restriction(s) if:

1. Except as otherwise required by law the disclosure is to a health plan for purposes of carrying out payment of healthcare operations (and is not for purposes of carrying out treatment): and
2. The medical information pertains solely to a healthcare item or service for which the healthcare provided involved has been paid out-of-pocket in full.

Once we agree to your request, we must follow your restrictions (except if the information is necessary for emergency treatment). You may cancel a restriction at any time. In addition, we may cancel a restriction at any time as long as we notify you of the cancellation and continue to apply the restriction to information collected before cancellation. You also have the right to request that we restrict disclosures of your medical information and healthcare treatment(s) to a health plan (health insurer) or other party, when that information relates solely to a healthcare item or service for which you, or another person on your behalf (other than a health plan) has paid us for in full. Once you have requested such restrictions(s), and your payment in full has been received, we must follow your restriction(s). To request restrictions, you may complete and submit the Right For Restriction On Use/Disclosure of Medical to the Privacy Officer.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you may complete and submit the Request For Restriction On Use/Disclosure of Medical Information And/Or Confidential Communication to the Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to Notification if a Breach of Your Medical Information Occurs: You also have the right to be notified in the event of a breach of medical information about you. If a breach of your medical information occurs, and if that information is unsecured (not encrypted) we will notify you promptly with the following information: A brief description of what happened; A description of the health information that was involved.

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 it electronically, you are still entitled to a paper copy. To obtain such a copy, contact the Privacy Officer.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and 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 summary of the current notice in the office with its effective date in the top right-hand corner. You are entitled to a copy of the notice currently in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the Privacy Officer of the Sycamore Fire Department at 815-895-4514. You will not be penalized for filing a complaint.

BILLING AUTHORIZATION RESPONSIBILITY FOR PAYMENT AND RECEIPT OF NOTICE OF PRIVACY RIGHTS

I understand that I am financially responsible for the services provided to me by Sycamore Fire Department regardless of insurance coverage. I request the payment of authorized Medicare or other insurance benefits be made on my behalf to the Sycamore Fire Department for any services provided to me by Sycamore Fire Department.

I authorize and direct any holder of medical information or documentation about me to release to the Centers for Medicare and Medicaid Services and its carriers and agents, as well as to Sycamore Fire Department and its billing agents and other payers of insurers, any information or documentation needed to determine these benefits or benefits payable for any services provided to me by Sycamore Fire Department, now or in the future. I agree to immediately remit to Sycamore Fire Department any payments that I receive directly from any source for the services provided to me and I assign all rights to such payments to Sycamore Fire Department.

I also acknowledge that I have received a copy of the Sycamore Fire Department Notice of Privacy Practices. A copy of this form is as valid as the original.

_____

Signature of Patient or Authorized Patient's Representative

_____ _____

PRINT NAME OF PATIENT or NAME OF REPRESENTATIVE **DATE**

Authorized representatives include **only** the following individuals: Patient's Legal Guardian; Patient's Health Care Power of Attorney; Relative or other person who receives government benefits on behalf of patient; Relative or other person who arranges treatment or handles the patient's affairs; Representative of an agency or institution that furnished care, services or assistance to the patient.

Reason the patient is physically or mentally incapable of signing: _____

_____

I am signing on behalf of the patient. I recognize that signing on behalf of the patient is not an acceptance of financial responsibility for the services rendered.

EMERGENCIES ONLY-AMBULANCE CREW

Complete this section **only** if **all** of the following are true; **(1)** the call is an **emergency** ambulance transport, **(2)** the patient was physically or mentally incapable of signing, **and (3)** no authorized representative was available or willing to sign on behalf of the patient at the time of service.

PATIENT NAME: _____ TRANSPORT DATE: _____

A. Ambulance Crew Member Statement (must be completed by crew member at time of transport)
My signature below indicates that, at the time of service, the patient was physically or mentally incapable of signing, and that none of the authorized representatives were available or willing to sign on the patient's behalf.

Reason patient is incapable of signing _____

Name of Receiving Facility: _____ Time of Receiving Facility _____

_____ _____

Printed Name of Crewmember **Signature of Crewmember**

B. Receiving Facility Representative Signature
The patient named on this form was received by this facility at the date and time indicated above. **This signature is not an acceptance of financial responsibility for the services rendered to this patient.**

_____ _____

Printed Name and Title of Receiving Facility Representative **Signature of Receiving Facility Representative**

C. Secondary Documentation (required only if signature in Section B cannot be obtained)
If no facility representative signature is obtained, the ambulance crew should attempt to obtain one or more of the following forms of documentation from the receiving facility that indicates that the patient was transported to that facility by ambulance on the date and time indicated above. The release of this information by the hospital to the ambulance service is expressly permitted by §164.506(c) of HIPAA.

☐ Patient Care Report (signed by representative of Facility)

☐ Patient Medical Record

Due to the extenuating circumstances presented by COVID-19, in lieu of a written signature, the patient may have consented and agreed verbally to receipt of Notice of Privacy Rights, billing authorization and responsibility for payment, as noted in the patient care report.