Consent for Services
Notice of Privacy Practices
Authorization to Release to Insurance

Client Name: _____ Date of Birth: _____ ____ M ____ F

Address: _____ City: _____ State: _____ Zip Code: _____

Phone ( ) _____ ( ) _____ Race: _____ Ethnicity: ____ Hispanic ____ Non Hispanic

Parent: (1) _____ Parent: (2) _____

CONSENT FOR SERVICES

I request and consent to any examination, testing and medical treatment found to be necessary by the medical staff of the Vanderburgh County Health Department (VCHD). I understand my treatment will be based on my medical history (which may include sexual history), physical examination and/or laboratory findings and that it is important for me to give accurate information. I understand that I have the right to be informed about specific services and procedures, including information about risks, benefits and alternatives to each service proposed for my treatment. I understand that there may be a fee for the services that I am provided.

Services may include but not be limited to, Vaccines, Tuberculosis (TB) Skin Testing and Evaluation, Blood Pressure Screening, STD Screening, HIV Testing, Blood Lead Testing, Blood draw for Cholesterol/Glucose/Lipid Profile, Blood draw, Medications, and/or Pregnancy Testing.

_____ (initials) For certain diseases and conditions, it is necessary that we provide assessment, treatment, or other services in your home. In most cases, these visits will be done by appointment, but it is important that we have written consent to be in your home or on your property to provide these services to you. By initialing here, you are indicating that you provide consent for us to be in your home if necessary to assist with your/your child's care. *If yes, please initial.*

_____ (initials) Would you allow a student to observe or participate in your care? *If yes, please initial.*

By signing below, I attest to all statements above and that all health history questions will be answered truthfully and to the best of my knowledge.

_____

Please Print Name of Patient

_____ Self Parent/Guardian _____

Client Signature (or parent/guardian if client is a minor) Date

I have translated this entire document for the above-named patient, who has indicated their understanding of the information provided.

Translator Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act (HIPAA) requires healthcare entities to provide clients a Notice of Privacy Practices and that clients acknowledge receiving the notice.

I understand that the Vanderburgh County Health Department (VCHD) will use and disclose my protected health information only for treatment, payment, and health care operations, or when required by law. I understand that these uses and disclosures of my protected health information are described more completely in the department's *Notice of Privacy Practices*. I understand I have the following rights:

• The right to receive and review the department's Notice of Privacy Practices before signing this consent.
• The right to request restrictions or limits on how protected health information about me is used or disclosed for treatment, payment or healthcare operations and VCHD is not required to agree to restrictions.
• The right to file a complaint with this department and with the U.S. Department of Health and Human Services (Office of Civil Rights: 312-886-2359) with no fear of retaliation, if I believe my privacy rights have been violated.

I consent to the use and disclosure by VCHD and its agents or representatives of all my personal health information for purposes of treatment, payment and healthcare operations. I understand that this consent will remain in effect unless I give written notice to revoke. By signing below, I acknowledge that I was given the opportunity to review the privacy notice.

_____

Please Print Name of Patient

_____ Self Parent/Guardian _____

Client Signature (or parent/guardian if client is a minor) Date

AUTHORIZATION TO RELEASE INFORMATION TO INSURANCE CARRIER

The Vanderburgh County Health Department (VCHD) relies on client fees and Insurance/Medicaid billing to be able to offer quality public health services. Payment is due when services are provided unless prior arrangements have been made. Any charges for services requested by the client to be rendered at an off-site location or laboratory are also due at time of visit.

Insurance Information

Plan Type: ____ Private ____ Medicaid ____HIP ____ Medicare ____ Other _____ ____ None

Insurance/Plan Name: _____Group/Policy Number: _____

Member's Name: _____ Member's Date of Birth _____ Gender ____ M ____ F

Relationship to Member: ____ Self ____ child _____spouse ____ other _____

I certify the information supplied above is accurate. By signing I am indicating that my answers have been completely truthful and that I understand that intentionally falsifying insurance information could constitute insurance fraud. I understand that VCHD will release medical and related information to my health insurance company, Medicaid, Medicare or other third party payer at their request and without additional notice to me. Policies are in place to assure privacy is maintained related to confidential services.

_____

Please Print Name of Patient

_____ Self Parent/Guardian _____

Client Signature (or parent/guardian if client is a minor) Date

The consent(s)/permission(s) provided/granted within this document are good for a period of one (1) year from the date this form is signed unless otherwise noted herein or provided in writing to the Department. Following that 1 year period, all information is considered null and void.

NOTICE OF PRIVACY PRACTICES
VANDERBURGH COUNTY HEALTH 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: our Privacy Contact or designee at (812) 435-2440.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. The VCHD is required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following any breach of unsecured protected health information. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices through our website at http://www.vanderburghcounty.in.gov/health or by mail, fax or at a future appointment.

1. Uses and Disclosures of Protected Health Information:

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION BASED UPON YOUR WRITTEN CONSENT

You will be asked by the health department to sign a consent form and an acknowledgement of your receipt of this Notice of Privacy Practices. Once you have consented to use and disclosure of your protected health information for treatment, payment and health care operations by signing the consent form, the health department will use or disclose your protected health information as described in this Section 1. Your protected health information may be used and disclosed by the health department, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the health department's functions.

Following are examples of the types of uses and disclosures of your protected health care information that the health department is permitted to make once you have signed our consent form. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by the health department once you have provided consent.

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we may disclose your protected health information, as necessary, to agencies that provide services to you. We may also disclose protected health information, such as immunization records, to other physicians who may be treating you when we have the necessary permission from you to disclose your protected health information. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of the health department, becomes involved in your care by providing assistance with your health care diagnosis or treatment.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. The VCHD will abide, at the request of an individual, to restrict disclosure of services to a health care plan for which the individual has paid out of pocket, in full.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of the health department. These activities include, but are not limited to, quality assessment activities; employee review activities; training of students; licensing; business planning and development; business management and general administrative activities; and conducting or arranging for other business activities. For example, we may allow access to your protected health information to students during their health department training

OTHER PERMITTED USES AND DISCLOSURES THAT MAY BE MADE WITH YOUR CONSENT, AUTHORIZATION, OR OPPORTUNITY TO OBJECT

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then the health department may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Appointment Reminders and Other Incidental Uses and Disclosures: From time to time incidental uses and disclosure of your information may occur. We will use our best reasonable effort to limit these incidental uses and disclosures to the minimum amount necessary to provide you with services. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when we are ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

Treatment Alternatives, Benefits and Services: We may disclose your health information to tell you about possible treatment options or alternatives, health-related benefits or other services that may be of interest to you, or to recommend possible treatment options or alternatives that may be of interest to you.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative, or any other person that is responsible for your care of your location, general condition, or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, the health department shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If the health department has attempted to obtain your consent but is unable to obtain your consent, the health department may still use or disclose your protected health information to assure treatment.

Research: We may use or disclose certain health information about your condition and treatment for research purposes where an Institutional Review Board or similar body referred to as a Privacy Board determines that your privacy interests will be adequately protected in the study. We may also use and disclose your health information to prepare or analyze a research protocol and for other research purposes.

Business Associates: We may share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the health department. Whenever an arrangement between the health department and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

SPECIAL USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION BASED UPON YOUR WRITTEN CONSENT

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, for determining cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye, or tissue donation purposes.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and the health department created or received your protected health information in the course of providing care to you.

Communication Barriers: We may use and disclose your protected health information if the health department attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the health department determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally established programs.

Litigation: We may disclose your health information for legal or administrative proceedings that involve you. We may release such information upon order of a court

or administrative tribunal. We may also release health information in the absence of such an order and in response to a discovery or other lawful request, if efforts have been made to notify you or secure a protective order.

OTHER REQUIRED USES AND DISCLOSURES THAT MAY BE MADE WITHOUT YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury, or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Abuse or Neglect: We may disclose your protected health information to the appropriate authorities that are authorized by law to receive reports of abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect, or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, or to track products; to enable product recalls, to make repairs or replacements, or to conduct post marketing surveillance, as required.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system or enforce civil rights laws, government benefit programs, and other government regulatory programs.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes may include (1) legal processes and as otherwise required by law, (2) limited information requests for identification and location purposes, (3) information pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) a criminal occurrence on the premises of the health department and (6) a medical emergency (not on the health department's premises) that may have involved a criminal act. Note: Protected health information obtained by the Communicable Disease Division, whether collected from client records or other sources, will not be released except as specified by IC 16-41-8-1(b).

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request, or other lawful process.

Federal Intelligence and Counter-Intelligence: We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Communicable Diseases: We may disclose your protected health, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Required Uses and Disclosures: Under the law, we must make disclosures about you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of CFR Parts 160 and 164.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION BASED UPON YOUR WRITTEN AUTHORIZATION

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that an action has already occurred based on this authorization.

2. Your Rights:

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights. Any request concerning your protected health information must be received in writing; written requests will be acted on within 30 days.

You have the right to request a restriction of your protected health information: This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

The health department is not required to agree to a restriction that you may request. If the Health Officer or his/her designee believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If the health department does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with the health department. You must request a restriction in writing.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location: We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.

You have the right to inspect and copy your protected health information: This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that the health department uses for making decisions about you excluding sensitive information such as communicable disease contacts.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Contact if you have questions about access to your medical record.

You may have the right to have the health department amend your protected health information: This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Contact to determine if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information: This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you. You have the right to receive specific information regarding any disclosures made in the six (6) years prior to the date of your request; provided, however, you have no right to an accounting of disclosures made prior to April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions, and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. Complaints:

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Contact or designee of your complaint at (812) 435-2440. You may also contact the Secretary of the Department of Health and Human Services, at 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201 (e-mail: ocrmail@hhs.gov). We will not retaliate against you for filing a complaint.

4. Changes to This Notice:

We reserve the right to change this Notice. We reserve the right to make the revised or changed notice effective with 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 as described above. The Notice will contain the effective date. A copy of the current notice in effect will be available to you on each visit at the Vanderburgh County Health Department.

You may contact our Privacy Contact or designee at (812) 435-2440 for further information about the complaint process.

This notice was published and became effective on April 14, 2003.

This notice was revised February10, 2005, reviewed 1/9/08, revised May 19, 2009, revised September 5, 2013