****

**NOTICE OF PRIVACY PRACTICES**

|  |  |
| --- | --- |
| Siouxland Community Health Center1021 Nebraska StreetSioux City, IA 51105<https://slandchc.com>Compliance Officer Phone: (712) 226-8983Email Address: mnitz@slandchc.com | Siouxland Community Health of Nebraska3410 Futures DriveSouth Sioux City, NE 68776<https://slandchc.com>Compliance Officer Phone: (712) 226-8983Email Address: mnitz@slandchc.com |

**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.**

**YOUR RIGHTS**

**You have the right to:**

* Get a copy of your paper or electronic medical record
* Ask us to correct or amend your paper or electronic medical record
* Request confidential information
* Ask us to limit the information we share
* Get a list of those with whom we’ve shared your information
* Get a copy of this privacy notice
* Choose someone to act for you
* File a complaint if you believe your privacy rights have been violated

**See pages 2 and 3** for more information on these rights and how to exercise them

**YOUR CHOICES**

**You have some choices in the way that we use and share information as we:**

* Tell family and friends about your condition
* Provide disaster relief
* Provide mental health care
* Market our services and sell your information
* Raise funds

**See page 3** for more information on these choices and how to exercise them

**OUR USES AND DISCLOSURES**

**We may use and share your information as we:**

* Treat you
* Run our organization
* Bill for your services
* Help with public health and safety issues
* Do research
* Comply with the law
* Respond to organ and tissue donation requests
* Work with a medical examiner or funeral director
* Address workers’ compensation, law enforcement, and other government requests
* Respond to lawsuits and legal actions
* Perform quality assessment and improvement activities, including patient satisfaction surveys

**See pages 4 through 6** for more information on these uses and disclosures

**YOUR RIGHTS**: **When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

**Get an electronic or** You can ask to see or get an electronic or paper copy of your medical record and

**paper copy of your** other health information we have about you. Ask us how to do this.

**medical record**

Requests to access, exchange, or use electronic health information may be made through the patient portal website or via written request.

We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

…………………………………………………………………………………………………………………………...

**Ask us to correct** You can ask us to correct or amend health information about you that you think

**your medical record is** incorrect or incomplete. Ask us how to do this.

 We may say “no” to your request, but we’ll tell you why in writing within 60

 days.

…………………………………………………………………………………………………………………………..

**Request confidential** You can ask us to contact you in a specific way (for example, home or office

**communications** phone) or to send email to a different address.

 We will say “yes” to all reasonable requests.

…………………………………………………………………………………………………………………………...

**Ask us to limit what** You can ask us **not** to use or share certain information for treatment, payment or

**we use or share** our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.

If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

…………………………………………………………………………………………………………………………..

**Get a list of those** You can ask for a list (accounting) of the times we’ve shared your health

**with whom we’ve** information for six years prior to the date you ask, who we shared it with, and

**shared information** why.

 We will include all of the disclosures except for those about treatment, payment,

 and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

…………………………………………………………………………………………………………………………...

**Get a copy of this** You can ask for a paper copy of this notice at any time, even if you have agreed

**privacy notice** to receive the notice electronically. We will provide you with a paper copy promptly.

…………………………………………………………………………………………………………………………...

**Choose someone to** If you have given someone medical power of attorney or if someone is your

**act for you** legal guardian, that person can exercise your rights and make choices about your health information.

 We will make sure the person has this authority and can act for you

 before we take any action.

…………………………………………………………………………………………………………………………...

**File a complaint if** You can complain if you feel we have violated your rights by contacting us

**you feel your rights** using the information on page 1.

**are violated**

You can file a complaint with the U.S. Department of Health and Human

Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**

We will not retaliate against you for filing a complaint.

…………………………………………………………………………………………………………………………...

**YOUR CHOICES: For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

**In these cases, you have** Share information with your family, close friends, or others involved in your

**both the right and choice** care

**to tell us to:**

 Share information in a disaster relief situation

*If you are not able to tell us your preference, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

*………………………………………………………………………………………………………………....*................................

**In these cases we *never*** Marketing purposes

**share your information** Sale of your information

**unless you give us** Most sharing of psychotherapy notes

**written permission: Any other uses/disclosures of your information not described in this notice**

 ***If you provide a written permission for us to disclose your information,***

 ***you may revoke it at any time by following the procedure set forth in the***

 ***authorization form. Your revocation will not be effective with respect to***

 ***any release made prior to your revocation.***

.......................................................................................................................................................................................

**In the case of fundraising:** We may contact you for fundraising efforts, but you can tell us not to contact you

again.

........................................................................................................................................................................................

**OUR USES AND DISCLOSURES: How do we typically use or share your health information?** We typically use or share your health information in the following ways.

**Treat you** We can use your health information *Example: A doctor treating you for an injury*and share it with other professionals *asks another doctor about your overall health*

who are treating you.*condition.*

…………………………………………………………………………………………………………………………...

**Run our** We can use and share your health *Example: We use health information about you*

**organization** information to run our practice, *to manage your treatment and services.*

improve your care, and contact

you when necessary.

…………………………………………………………………………………………………………………………

**Bill for your** We can use and share your health *Example: We give information about you to*

**services** information to bill and get payment *your health insurance plan so it will pay for*

from health plans or other entities. *your services.*

…………………………………………………………………………………………………………………………...

**How else can we use or share your health information?** We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: [**www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html)**.**

………………………………………………………………………………………………………

**Help with public health** We can share health information about you for certain

**and safety issues** situations such as:

* Preventing disease
* Helping with product recalls
* Reporting adverse reactions to medications
* Reporting suspected abuse, neglect or domestic violence
* Preventing or reducing a serious threat to anyone’s health or safety

………………………………………………………………………………………………………………………….

**Do research** We can use or share your information for health research.

…………………………………………………………………………………………………………………………...

**Comply with the law** We will share information about you if state or federal laws require it, including

with the Department of Health and Human Services if it wants to see that we’re

complying with federal privacy law.

...........................................................................................................................................................................................

**Respond to organ and** We can share information about you with organ procurement organizations.

**tissue donation requests**

..........................................................................................................................................................................................

**Work with a medical** We can share health information with a coroner, medical examiner, or funeral

**examiner or funeral** director when an individual dies.

**director**

…………………………………………………………………………………………………………………………...

**Address workers’** We can use or share health information about you for workers’ compensation

**compensation, law** claims, law enforcement purposes or with a law enforcement official, with **enforcement, and other** health oversight agencies for activities authorized by law, and for special

**government requests** government functions such as military, national security, and presidential protection services.

…………………………………………………………………………………………………………………………...

**Respond to lawsuits and** We can share health information about you in response to a court or

**legal actions** administrative order, or in response to a subpoena when the necessary

jurisdictional and statutory requirements have been met.

...........................................................................................................................................................................................

**Information with additional** Certain types of protected health information are afforded additional protection

**protections** under federal or state law. The State of Iowa provides greater protection for

health information about mental health and HIV/AIDS, and both Iowa and

federal law provide greater protection for alcohol and substance abuse. We will

follow all applicable state and federal laws that require greater limits on

disclosures and we will not share these records without your written permission.

…………………………………………………………………………………………………………………………...

**OUR RESPONSIBILITIES:**

* We are required by law to maintain the privacy and security of your protected health information.
* We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
* We must follow the duties and privacy practices described in this notice and give you a copy of it.
* We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

**GENERAL INFORMATION:**

For more information, see:

[www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

**Changes to the terms of this Notice:** We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

*Effective Date: January 1, 2013*

*Updated: June 6, 2016; July 19, 2018; November 20, 2020; December 19, 2022*

If you have any questions about this Notice, please contact the Compliance Officer at (712) 226-8983 or mnitz@slandchc.com.