HEALTH

2019-2020 BRH SCHOOL HEALTH CENTER STUDENT REGISTRATION & PERMISSION FORM

STUDENT INFORMATION **(Jackson County)** **ATTENDING SCHOOL:**

Name (Last, First, Middle)	Birth Date / /	Gender ☐ Male ☐ Female	Grade/ Teacher
Ethnicity ☐ Hispanic ☐ Non-Hispanic	Race ☐ Native American ☐ White ☐ African American ☐ Asian		Primary Language Spoken if Not English
Does the child have a regular doctor or other medical provider? ☐ Yes ☐ No Name of Provider or Clinic:	Does the child have a regular dentist or dental clinic provider? ☐ Yes ☐ No Name of Dentist or Dental Clinic:		

PARENT / COURT ORDERED LEGAL GUARDIAN INFORMATION

Name Date of Birth	Relationship to Student	Does student live with you? ☐ Yes ☐ No
Street Address	City, State, Zip	
Daytime Phone # / Work phone # and ext.	Other Phone (cell phone) #	Email Address
In Case of Emergency Contact/Relationship to Student	Phone #	Other Phone (cell phone) #

STUDENT MEDICAL HISTORY

Medication allergies: Reaction:

Other allergies: Reaction:

Daily medications: Reason for taking: How long have they taken this medication? Preferred Pharmacy:

Chronic Medical Conditions: **(Check all that apply)**

☐ Diabetes ☐ Attention Deficit Disorder (ADD/ADHD ☐ Asthma ☐ Sickle Cell Disease ☐ Kidney Disease ☐ Depression
☐ Heart Problems ☐ Anemia ☐ Epilepsy ☐ Autism/Autism Spectrum Disorder ☐ Developmental Delay
☐ Other Issues: _____

Has your child ever had chicken pox? ☐ Yes ☐ No **If yes, when?** / /

Has there been any change in your child's health during the past year? ☐ Yes ☐ No **If yes, explain.**

Has this child had a recent complete physical exam? ☐ Yes ☐ No **If yes, when?** / /

If no, Would you like for your child to receive a complete physical in the School Health Center? ☐ Yes ☐ No **If yes, please sign the statement below:**
I give permission for my child to have a complete physical exam at the School Health Center – signature: _____
I would like to be present for my child's exam. ☐ Yes ☐ No We will contact you before and after the appointment.

Has this child been seen in the emergency room in the past year? ☐ Yes ☐ No **If yes, when and why?**

Has this child ever had to stay in the hospital or have surgery? ☐ Yes ☐ No **If yes, when and why?**

Last dental exam? / / Any dental concerns? ☐ Yes ☐ No **If yes, explain.**

Has your child ever had any serious sports-related injuries? ☐ Yes ☐ No **If yes, give the age it occurred and describe injury.**

If your child receives a Sports Physical in the School Health Center: do you consent to releasing a copy of your child's completed sports physical forms to the school for sports participation purposes? ☐ Yes ☐ No

Is there anything else you would like for the school health center to know about your child?

HOUSEHOLD INFORMATION

Please name the people living in your household and their ages: **Example: Father (40), Stepmother (40), Sisters (6&8), Uncle (50), etc.**

Does anyone in the household smoke? ☐ Yes ☐ No

FAMILY MEDICAL HISTORY

Does anyone in this child's immediate family have any current health concerns? ***(Diabetes, High Blood Pressure, Asthma etc.)***

Family Member	Age	Health Concern

TURN OVER PLEASE – BACK OF FORM MUST BE COMPLETED

NOTICE AND ACKNOWLEDGMENT OF PRIVACY PRACTICES

Dear Parent/Guardian,

Enclosed you will find a **Notice of Privacy Practices** that details the way we keep your child's medical record confidential, and what rights you have to access that medical record. You will also find a form listing Student and Parent Rights & Responsibilities. We are required by Federal Law to provide you with this information and we ask that you **read the Notice of Privacy Practices and Rights & Responsibilities for both you and your child. Once complete, please sign this sheet and return it to us for our records.** Please call (828) 692-4289 and speak to our BRH Privacy Officer if you have any questions. Thank you for your cooperation in our effort to comply with this law.

Thanks!
Blue Ridge Health – School Health Center Staff

INSURANCE INFORMATION* Please send a copy of your insurance cards with this form or send the original **(we will make a copy and return the card to you)**

Is the student covered by Medicaid or NC Health Choice? ☐ Yes ☐ No ☐ Pending Medicaid or NC Health Choice ID#:	Would you like information about Medicaid or NC Health Choice? ☐ Yes ☐ No Do you have another child in the home on Medicaid/NC Health Choice? ☐ Yes ☐ No

Is the student covered by insurance? ☐ Yes ☐ No **(If NO, please fill out the sliding fee information below to qualify for discounted charges)**			Would you like information about how you could get insurance through the Health Insurance Marketplace? ☐ Yes ☐ No
Private Insurance	Name of Policyholder	Date of Birth	Relationship to student
Insurance Company Address **(to mail medical claims – check on the back of your insurance card)**			Insurance Phone #
ID Number (Policy #)	Group Number		Social Security # **(for insurance purposes only)**
Date Coverage Began		What is your deductible or co-pay?	
Policyholder's Employer		Employer Address	

Are you employed in Agriculture? ☐ Yes ☐ No

If yes, what type of position do you hold? ☐ Grower ☐ Migrant Farmworker (travel to seek work) ☐ Year-round Farmworker ☐ Seasonal Farmworker (live here; agriculture work during harvest season)

What was this child's birthplace? City: State: Country:

APPLYING FOR THE BRH DISCOUNT SERVICES PROGRAM: ☐ **Yes – I want more information on the BRH Discount Services Program**

If your child is uninsured at any time during the school year or you have a high insurance deductible plan, we would like to help by determining if you would qualify for discounted charges or our "sliding fee" which uses similar eligibility to the federal free and reduced lunch program. If you'd like to apply for this program, additional information must be completed to determine eligibility. Eligibility will be good for the entire school year.

1. I give consent for my child to receive any of the available services at a BRH Student Health Center. BRH School Health Centers provide medical & dental to enrolled students who have completed registration, including written consent and signature of the parent or legal guardian. Staff of the BRH School Health Center will inform parents of significant findings and treatment recommendations for minor children, for conditions other than those exempted by state law.
2. I authorize the release to my child's primary care provider & the JCPS Student Support Services any medical information pertinent to my child's general health and care while they are at school. I authorize the release of information from my child's primary care provider and the JCPS Student Support Services to the BRH School Health Center for coordination of care.
3. I authorize the release of any medical information, including information on communicable diseases, necessary to process an insurance claim for payment of medical benefits to the BRH School Health Centers.
4. I authorize payment of insurance benefits for services rendered at the BRH School Health Centers, though Blue Ridge Health. I understand that I am financially responsible for all charges and any co-pays or deductible amount not covered by my insurance. I further understand I am responsible for understanding my own insurance plan and whether services are covered or require pre-authorization. If services require pre-authorization, I understand this is my responsibility.
5. I understand that Blue Ridge Health (BRH) operates the School Health Centers and I must contact BRH to make special payment arrangements if I am unable to pay the bill in full.
6. I understand that my child's medical records will be strictly confidential, in compliance with state and federal laws, and will be maintained at the BRH SHC facility. Information is not shared with teachers, principals, or other students.
7. I confirm that all information given is complete and accurate.
8. I understand that by signing this form, I authorize my child to receive all services available from the School Health Center. I understand that this consent is voluntary and is valid for the entire time that my child is enrolled at a JCPS School. I understand that I may revoke my consent at any time. I understand that it is my responsibility to provide up-to-date information on the insurance coverage I carry on my child, including Medicaid and NC Health Choice.

Please sign the following declaration: **I certify that the information provided on this form is accurate and complete to the best of my knowledge.**

Parent/Guardian Signature:_____
Date:_____/_____/_____

NO STUDENT WILL BE DENIED HEALTH SERVICES BASED ON THEIR PARENT OR LEGAL GUARDIAN'S INABILITY TO PAY.

TURN OVER PLEASE – BACK OF FORM MUST BE COMPLETED

BLUE RIDGE HEALTH

APPLICATION FOR DISCOUNT SERVICES

Patient Name:_____ **Phone:** _____

Please mark each statement that applies to you or a family member who is also on this application. This information will not be used to withhold or deny services to you or your family.

I. SLIDING FEE SCHEDULE

As a Federally Qualified Health Center, BRCHS offers a Sliding Fee discount program for those who qualify. **You may receive the discounted rate even if you have private insurance**, Marketplace insurance, or Medicare, if the discounted rate is lower than your normal out-of-pocket cost. If you are not eligible for the sliding fee scale, choose not to apply, or do not provide household and income information, you will be expected to pay the full charge for care. (See the **Acknowledgement if NOT applying for Sliding Fee Schedule** at the end of this document).

I would like to see if I qualify for discount services under BRCHS's Sliding Fee Schedule. Yes_____ **No**_____

II. ELIGIBILITY VERIFICATION:

Household information: Please include yourself, your spouse/partner and all dependents living in the home below:

Name	Date of Birth	Relationship to You	Type of Health Insurance?	Farmworker in past 2 years?	Veteran?
		Self			

Gross Income: Please list your household's **gross income** (the $ amount received before taxes are taken out). Household income includes *everyone* in the home. Proof of income includes: most recent tax return, check stubs, Social Security statement, letter from employer stating wages earned, or proof of unemployment.

Income type (i.e. Wages, Soc. Sec., Child Support, other income)	**Name of Family Member**	**Gross Amt.** (pre-tax)	**Frequency** (weekly(x52), bi-weekly (x26), bi-monthly (X24) or monthly (x12))
		$	
		$	
		$	

If there is no income to report, or if you are unable to document your income, you must complete the **Patient Certification Statement** section below.

Patient Certification Statement

I certify that I have no other way to document my income and that all of the above information is accurate. I understand that this information is to be used to determine eligibility for the BRCHS Sliding Fee Discount Schedule. I understand that BRCHS officials may verify information on this form.

Patient Signature_____ **Date**_____

[OVER PLEASE]

Acknowledgement if NOT applying for Sliding Fee Schedule

I have been given the opportunity to apply for the BRCHS discount services sliding fee schedule, and **I do not wish to apply for the BRCHS discount services sliding fee program** at this time, or have been told that I do not qualify for a sliding fee discount. I understand that if I do not have insurance at the time of service, I will be responsible for any and all balances due after the provider's charges for my visit are entered. I will also be responsible for any lab and/or x-ray charges for today's visit. Any discount for office charges or lab charges is not applicable and I will not be allowed to receive a retroactive discount for these charges in the event that a future sliding scale application is completed.

Patient Signature_____ **Date:** _____

Consent for Application for Discount Services

I certify that the **information provided above is accurate and complete** to the best of my knowledge. In the event of a change in income or insurance coverage, I will notify BRCHS at my next appointment. I understand that **I will be financially responsible for all or a portion of my care** and that I will be **asked to submit payment at the time of service.** I authorize the release of any information necessary to establish my family's eligibility for discounted services and I give my consent to release my information to Pharmaceutical Companies for auditing purposes only for any Bulk Medication Patient Assistance Programs of which I may enrolled. I understand that BRCHS uses a system called Oasis Insight or an Electronic Health Record to help determine eligibility for sliding fee and other services and I consent to have the above information stored in those systems.

Patient Signature_____ **Date**_____

III. POTENTIAL BARRIERS TO CARE

This list is used to help us identify other areas in your life that may need some additional community resources. It will help us develop a plan of action, including referrals to appropriate departments and outside organizations. If you would like more information, or have any question on the items below, check the box so that a Patient Navigator can assist you.

Health Insurance / Health Care Access

- ☐ I need health insurance (Medicaid, ACA Insurance, Family Planning, or other programs)
- ☐ I need to sign up for Medicare or need Medicare Counseling (SHIIP)
- ☐ I need help completing a Charity Care applications for my local hospital system
- ☐ I need help paying for my medications (This does not include usage of a discounted medication or medication assistance program.)
- ☐ I need to apply for a tax exemption because I'm uninsured
- ☐ My application for Medicaid/ACA insurance was denied
- ☐ I need help getting to other important appointments

Housing

- ☐ I do not have housing (living in shelter, with friends, in a car, in a park, etc.)
- ☐ I would like assistance to find affordable housing
- ☐ I am at risk of losing my housing

Housing (Continued)

- ☐ There are unsafe conditions at my home (mold, leaks, peeling paint, etc.)
- ☐ I have difficulty paying heating/utility bills

Food

- ☐ I sometimes or often do not have enough food for myself and/or my family
- ☐ I would like to apply for Food Stamps (SNAP) benefits
- ☐ I was denied Food Stamps (SNAP)

Transportation

- ☐ I need help going to medical appointments
- ☐ The bus system does not go near where I live or work

Other

- ☐ I would like to register to vote
- ☐ I need help filing my taxes
- ☐ My disability application was denied
- ☐ Other barriers/challenges:

_____

_____

None:

- ☐ I do not need assistance at this time.

Blue Ridge Staff Name_____ Slide (A-E):_____ Entered into EHR (initials)_____

BLUE RIDGE
HEALTH

Parents or Legal Guardians of BRH School Health Center (SHC) Patients	
Your Right:	**Your Responsibility:**
To authorize your child to receive the medical, health education, behavioral health, nutrition and dental services of the SHC by signed permission.	To read and understand terms and use of the SHC services as described in the registration from and to sign the form signifying understanding of these terms and giving permission for the child to receive services.
To refuse or rescind permission for your child to receive SHC services.	To mark the registration from as a REFUSAL of permission for services and to sign it.
To refuse to sign the permission form for you child until you understand it.	To contact our staff to clarify any questions you may have about the terms of use of our services.
To be treated with courtesy, dignity and respect in all your interactions with SHC staff.	To treat the SHC staff with the same courtesy, dignity and respect you would want for yourself.
To refer you child for services at any time regardless of ability to pay for services.	To provide accurate and current information on health insurance coverage on your child, or if you do not have insurance, to provide accurate income information to benefit from the slide fee scale.
To be notified of your child's visits to the SHC medical provider either by phone for urgent/ uncommon conditions or by a note sent home with your child following the visit.	To provide accurate and current contact numbers, including an emergency number, on your child's registration form.
To have prompt and safe treatment for you child.	To provide accurate history of your child's medical conditions, current medications and allergies on your child's registration form. And to act on your medical provider's treatment recommendations including filling prescriptions, keeping referral appointments, etc.
To refuse any recommended medical treatment for your child.	To consult you usual family medical provider or other doctor, for the health and safety of your child, if asked to do so by our nurse practitioner.
To have the confidentiality of your child's medical record, including any family contact, medical or income information that you provided on the parental permission form protected.	To respect the confidentiality of others by refraining from discussing the medical conditions or family matters of other children at school.
To review your child's medical record ("chart") or request a copy of the record. However, any materials on the chart pertaining to pregnancy, sexually transmitted diseases, substance abuse or emotional disturbances (including mental health counseling records) are considered confidential by NC State Law.	To request copies of your child's medical record in writing with you signature, date and the signature of a witness. We will provide you with a pre-printed request form if you wish. You must request a copy of the child's sports physical in this way. We cannot give any copies from the medical record to your child without your written, witnessed and dated request.

BLUE RIDGE
HEALTH

Students who are Patients at the BRH School Health Center (SHC)	
Your Right:	**Your Responsibility:**
To come to the SHC to request an appointment with the nurse, health educator or counselor.	To request permission from your teacher to come to the SHC and to bring a note or hall pass with you.
To ask for an appointment without giving your reason to anyone.	To ask for appointments only for concerns about your health, not to get out of class.
To have privacy during any time you spend in the Health Center, including having your height and weight taken in private, having an uninterrupted appointment time with the nurse or counselor, and have the health center staff respect your privacy by not discussing you our your health concern without your permission.	To respect the privacy of others by not asking us what's wrong with someone else and not to pester another student to tell you what's wrong with them, either.
To be treated with respect and courtesy by our staff.	To treat our staff members with the same respect and courtesy you would want for yourself.
To request that you be seen sooner than the next available appointment if you think your problem is serious enough.	To be honest about your problem with whoever is asking you about it and to accept the decision of the nurse when he or she decides when you appointment will be.
To request another appointment if you have waited so long for the one you came down for that you are missing a core class or lunch.	To watch the clock and come for your appointment on time.
To offer feedback on how good (or bad) the Health Center staff is at helping you with your problem.	Fill out a suggestion slip on the counter in the Health Center or ask to speak with a staff member about your concern.
To go over your medical record ("Chart") with the nurse. However, you do not have the right to ask for copies of any of the documents in your medical record (only your parent or guardian can.)	To notify the Health Center staff, in advance, if you will need copies of any documents from your chart (such as a sports physical). Do not wait until the day you need it. Appropriate parental or guardian permissions are required.
To tell Health Center staff any personal information such as emotional concerns or worries, something about trying drugs or alcohol that you are upset about, or a concern that you might be pregnant or have a sexually transmitted disease. You can be sure that your information will be kept private, even from your teacher and parents unless you give permission to tell someone. However, if you tell the Health Center staff member about wanting to hurt yourself or someone else or about someone who has abused you, the law says that we must seek help for you.	To be honest about the things you tell our staff members and not to make things up or even stretch the truth. We count on your honesty to know the right things to do to help you.

ıay obtain an electronic copy of your medical records. You may also instruct us in ‘riting to send an electronic copy of your medical records to a third party. If you ‘ould like to inspect or receive a copy of medical information about you, you must rovide us with a request in writing. You may write us a letter requesting this type f access.

/e may deny your request in certain circumstances. If we deny your request, we ‘ill explain our reason for doing so in writing. We will also inform you in writing if ou have the right to have our decision reviewed by another person.

you would like a copy of the medical information about you, we will provide one opy free of charge. Any additional request within a 12 month period will incur a ıarge to cover the costs of the copy (see rates below). Our fees for electronic oples of your medical records will be limited to the direct labor costs associated ith fulfilling your request.

ısk for the handout regarding costs of copying medical records & accounting of disclosures

/e may be able to provide you with a summary or explanation of the formation. Contact our Privacy Officer for more information on these services and ıy possible additional fees.

Right to Have Medical InformationAmended

ou have the right to have us amend (which means correct or supplement) edical information about you that we maintain in certain groups of records. If you elieve that we have information that is either inaccurate or incomplete, we may nend the information to indicate the problem and notify others who have copies the inaccurate or incomplete information. If you would like us to amend formation, you must provide us with a request in writing and explain why you ould like us to amend the information. You may write us a letter requesting an nendment.

e may deny your request in certain circumstances. If we deny your request, we ll explain our reason for doing so in writing. You will have the opportunity to send a statement explaining why you disagree with our decision to deny your ıendment request and we will share your statement whenever we disclose the ormation in the future.

Right to an Accounting of Disclosures We Have Made

ıu have the right to receive an accounting (which means a detailed listing) of sclosures that we have made for the previous six (6) years. If you would like to ceive an accounting, you may send us a letter requesting an accounting of sclosures.

e accounting will not include several types of disclosures, including disclosures treatment, payment or healthcare operations. If we maintain your medical cords in an Electronic Health Record (EHR) system, you may request that include closures for treatment, payment or healthcare operations. The ac- counting will o not include disclosures made prior to April 14, 2003.

ou request an accounting more than once every twelve (12) months, we may arge you a fee to cover the costs of preparing the accounting:

k for the handout regarding costs of copying medical records & accounting of disclosures.

Right to Request Restrictions on Uses and Disclosures

ı have the right to request that we limit the use and disclosure of medical ormation about you for treatment, payment and healthcare operations. Under eral law, we must agree to your request and comply with your requested triction(s) if:

1. Except as otherwise required by law, the disclosure is to a health plan for purpose 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.

ce we agree to your request, we must follow your restrictions (except if the rmation is necessary for emergency treatment). You may cancel the restrictions ny time. In addition, we may cancel a restriction at any time as long as we notify of the cancellation and continue to apply the restriction to information ected before the cancellation.

also have the right to request that we restrict disclosures of your medical rmation 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 restriction(s), and your payment in full has been received, we must follow your restriction(s).

6. Right to Request an Alternative Method of Contact

You have the right to request to be contacted at a different location or by a different method. For example, you may prefer to have all written information mailed to your work address rather than to your home address.

We will agree to any reasonable request for alternative methods of contact. If you would like to request an alternative method of contact, you must provide us with a request in writing. You may write us a letter to request an alternative method of contact.

7. 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
- Recommended steps you can take to protect yourself from harm
- What steps we are taking in response to the breach
- Contact procedures so you can obtain further information.

8. Right to Opt-Out of Fundraising Communications

If we conduct fundraising and we use communications like the U.S. Postal Service or electronic email for fundraising, you have the right to opt-out of receiving such communications from us. Please contact our Privacy Officer to opt-out of fundraising communications if you chose to do so.

YOU MAY FILE A COMPLAINT ABOU T OUR PRIVACY PRACTICIES

If you have concerns about patient care or safety please ask to speak with the BRCHS Privacy Officer so your concern may be documented and addressed. If you believe that your privacy rights have been violated or if you are dissatisfied with our privacy policies or procedures, you may file a written complaint either with us or with the federal government.

We will <u>not</u> take any action against you or change our treatment of you in any way if you file a complaint.

To file a written complaint with us, you may bring your complaint directly to our Privacy Officer, or you may mail it to the followingaddress:

Blue Ridge Community HealthServices
Attention: HIPAA Privacy Officer 2579
Chimney Rock Road Hendersonville, NC
28792

To file a complaint with the Joint Commission, please use the following contact information:

Office of Quality Monitoring
The Joint Commission
One Renaissance Boulevard
Oakbrook Terrace, IL 60181

Toll-Free Phone: 1-(800)-944-6610
Email: complaint@jcaho.org

To file a written complaint with the federal government, please use the following contact information:

Office for Civil Rights
U.S. Department of Health and Human Services 200
Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Toll-Free Phone: 1-(877) 696-6775
Website: http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html
Email: OCRComplaint@hhs.gov

BLUE RIDGE HEALTH

Notice of Privacy Practices

Effective Date: July 15, 2005
Revision Date: March 26, 2013

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 questions about this notice, contact the Blue Ridge Health HIPAA Privacy Officer at 828-692-4289.

WHO WILL FOLLOW THIS NOTICE

This notice describes Blue Ridge Community Health Services' practices and that of:

- Any health care professional authorized to enter information into your medical chart.
- All Blue Ridge Community Health Services entities, sites, and locations.
- All departments of Blue Ridge Community Health Services.
- All employees, staff, volunteers, and other personnel of Blue Ridge Com- munity Health Services.

All Blue Ridge Community Health Services entities, sites and locations follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for treatment, payment or healthcare operation purposes described in this notice.

WE MAY USE & DISCLOSE MEDICAL INFORMATION ABOUT YOU IN SEVERAL CIRCUMSTANCES

We use and disclose medical information about patients every day. This section of our Notice explains in some detail how we may use and disclose medical information about you in order to provide healthcare, obtain payment for that healthcare, and operate our business efficiently. This section then briefly mentions several other circumstances in which we may use or disclose medical information about you. For more information about any of these uses or disclosures, or about any of our privacy policies, procedures or practices, contact our Privacy Officer at **828-692-4289.**

1. Treatment

We may use and disclose medical information about you to provide healthcare treatment to you. In other words, we may use and disclose medical information about you to provide, coordinate or manage your healthcare and related services. This may include communicating with other healthcare providers regarding your treatment and coordinating and managing your healthcare with others.

Example: **Jane is a patient at the health department. The receptionist may use medical information about Jane when setting up an appointment. The nurse practitioner will likely use medical information about Jane when reviewing Jane's condition and ordering a blood test. The laboratory technician will likely use medical information about Jane when processing or reviewing her blood test results. If, after reviewing the results of the blood test, the nurse practitioner concludes that Jane should be referred to a specialist, the nurse may disclose medical information about Jane to the specialist to assist the specialist in providing appropriate care to Jane.**

2. Payment

We may use and disclose medical information about you to obtain payment for healthcare services that you received. This means that, within the health department, we may *use* medical information about you to arrange for payment such as preparing bills and managing accounts). We also may disclose medical information about you to others (such as insurers, collection agencies, and consumer reporting agencies). In some instances, we may disclose medical information about you to an insurance plan *before* you receive certain healthcare services because, for example, we may need to know whether the insurance plan will pay for a particular service.

Example: **Jane is a patient at the health department and she has private insurance. During an appointment with a nurse practitioner, the nurse practitioner ordered a blood test. The health department billing clerk will use medical information about Jane when he prepares a bill for the services provided at the appointment and the blood test. Medical information about Jane will be disclosed to her insurance company when the billing clerk sends in the bill.**

3. Healthcare Operations

We may use and disclose medical information about you in performing a variety of business activities that we call "healthcare operations." These "healthcare operations" activities allow us to, for example, improve the quality of care we provide and reduce healthcare costs. For example, we may use or disclose medical information about you in performing the following activities:

- Reviewing and evaluating the skills, qualifications, and performance of healthcare providers taking care of you.
- Providing training programs for students, trainees, healthcare providers or non-healthcare professionals to help them practice or improve their skills.
- Cooperating with outside organizations that evaluate, certify or license healthcare providers, staff or facilities in a particular field or specialty.
- Reviewing and improving the quality, efficiency and cost of care that we provide to you and our other patients.
- Improving healthcare and lowering costs for groups of people who have similar health problems and helping manage and coordinate the care for these groups of people.
- Cooperating with outside organizations that assess the quality of the care others and we provide, including government agencies and private organizations.
- Planning for our organization's future operations.
- Resolving grievances within our organization.
- Reviewing our activities and using or disclosing medical information in the event that control of our organization significantly changes.
- Working with others (such as lawyers, accountants and other providers) who assist us to comply with this Notice and other applicable laws.

Example: **Jane was diagnosed with diabetes. The health department used Jane's medical information – as well as medical information from all of the other health department patients diagnosed with diabetes – to develop an educational program to help patients recognize the early symptoms of diabetes. (Note: The educational program would not identify any specific patients without their permission).**

4. Persons Involved in Your Care

We may disclose medical information about you to a relative, close personal friend or any other person you identify if that person is involved in your care and the information is relevant to your care. If the patient is a minor, we may dis- close medical information about the minor to a parent, guardian or other person responsible for the minor except in limited circumstances. For more information on the privacy of minors' information, contact our Privacy Officer at **828-692- 4289.**

We may also use or disclose medical information about you to a relative, another person involved in your care or possibly a disaster relief organization (such as the Red Cross) if we need to notify someone about your location or condition.

You may ask us at any time not to disclose medical information about you to persons involved in your care. We will agree to your request and not disclose the information except in certain limited circumstances (such as emergencies) or if the patient is a minor. If the patient is a minor, we may or may not be able to agree to your request.

Example: ***Jane's husband regularly comes to the health department with Jane for her appointments and he helps her with her medication. When the nurse practitioner is discussing a new medication with Jane, Jane invites her husband to come into the private room. The nurse practitioner discusses the new medication with Jane and Jane's husband.***

5. Required by Law

We will use and disclose medical information about you whenever we are required by law to do so. There are many state and federal laws that require us to use and disclose medical information. For example, state law requires us to report gunshot wounds and other injuries to the police and to report known or suspected child abuse or neglect to the Department of Social Services. We will comply with those state laws and with all other applicable laws.

6. National Priority Uses and Disclosures

When permitted by law, we may use or disclose medical information about you without your permission for various activities that are recognized as "national priorities." In other words, the government has determined that under certain circumstances (described below), it is so important to disclose medical information that it is acceptable to disclose medical information without the individual's permission. We will only disclose medical information about you in the following circumstances when we are permitted to do so by law. Below are brief descriptions of the "national priority" activities recognized by law. For more information on these types of disclosures, contact our Privacy Officer at **828-692-4289.**

- **Threat to health or safety:** We may use or disclose medical information about you if we believe it is necessary to prevent or lessen a serious threat to health or safety.
  Public health activities: We may use or disclose medical information about you for public health activities. Public health activities require the use of medical information for various activities, including, but not limited to, activities related to investigating diseases, reporting child abuse and neglect, monitoring drugs or devices regulated by the Food and Drug Administration, and monitoring work-related illnesses or injuries. For example, if you have been exposed to communicable disease (such as a sexually transmitted disease), we may report it to the State and take other actions to prevent the spread of the disease.
- **Abuse, neglect or domestic violence:** We may disclose medical information about you to a government authority (such as the Department of Social Services) if you are an adult and we reasonably believe that you may be a victim of abuse, neglect or domestic violence.
- **Health oversight activities:** We may disclose medical information about you to a health oversight agency – which is basically an agency responsible for overseeing the healthcare system or certain government programs. For example, a government agency may request information from us while they are investigating possible insurance fraud.
- **Court proceedings:** We may disclose medical information about you to a court or an officer of the court (such as an attorney). For example, we would disclose medical information about you to a court if a judge orders us to do so.
- **Law enforcement:** We may disclose medical information about you to a law enforcement official for specific law enforcement purposes. For example, we may disclose limited medical information about you to a police officer if the officer needs the information to help find or identify a missing person.
- **Coroners and others:** We may disclose medical information about you to a coroner, medical examiner, or funeral director or to organizations that help with organ, eye and tissue transplants.
- **Workers' compensation:** We may disclose medical information about you in order to comply with workers' compensation laws.
- **Research organizations:** We may use or disclose medical information about you to research organizations if the organization has satisfied certain conditions about protecting the privacy of medical information.
- **Certain government functions:** We may use or disclose medical information about you for certain government functions, including but not limited to military and veterans' activities and national security and intelligence activities. We may also use or disclose medical information about you to a correctional institution in some circumstances.

7. Authorizations

Other than the uses and disclosures described above (#1-6), we will not use or disclose medical information about you without the "authorization" – or signed permission – of you or your personal representative. In some instances, we may wish to use or disclose medical information about you and we may contact you to ask you to sign an authorization form. In other instances, you may contact us to ask us to disclose medical information and we will ask you to sign an authorization form.

If you sign a written authorization allowing us to disclose medical information about you, you may later revoke (or cancel) your authorization in writing (except in very limited circumstances related to obtaining insurance coverage). If you would like to revoke your authorization, you may write us a letter revoking your authorization or fill out an Authorization Revocation Form. Authorization Revocation Forms are available from our Privacy Officer. If you revoke your authorization, we will follow your instructions except to the extent that we have already relied upon your authorization and taken some action.

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.
- ☐ Any other uses and disclosures not described in this Notice.

YOU HAVE RIGHTS WITH RESPECT TO MEDICAL INFORMATION ABOUT YOU

You have several rights with respect to medical information about you. This section of the Notice will briefly mention each of these rights. If you would like to know more about your rights, please contact our Privacy Officer at: **828-692-4289.**

1. Right to a Copy of This Notice

You have a right to have a paper copy of our Notice of Privacy Practices at any time. In addition, a copy of this Notice will always be posted in our waiting area. If you would like to have a copy of our Notice, ask the receptionist for a copy or contact our Privacy Officer at **828-692-4289.**

2. Right of Access to Inspect and Copy

You have the right to inspect (which means see or review) and receive a copy of medical information about you that we maintain in certain groups of records. If we maintain your medical records in an Electronic Health Record (EHR) system, you