King's Daughters

WALK-IN CARE FOR SCHOOLS
CONSENT FOR SERVICES
2023-2024 SCHOOL YEAR

INITIAL OFFERING OF SERVICES

❑ Yes. I would like my child to access these services. I have completed all the information.
❑ No, I do not want my child to access these services.

Please read carefully: In order for UK King's Daughters ("KDMC," "we" or "us") to see a student at the school listed below, all pages of this form must be completed by the student's parent or legal guardian, signed and dated in ink in the appropriate places. Students should return the completed form to their homeroom teacher or other appropriate school representative. Consent is for the 2023-2024 school year and may be withdrawn at any time in writing by the signatory below.

1. STUDENT INFORMATION

Today's date: / /

School district: School name:

Student name: Gender: ❑ Male ❑ Female Date of birth: / /

Address:

City: State: Zip code:

Home telephone: Mobile telephone:

2. EMERGENCY CONTACT INFORMATION

Mother or legal guardian - full name:

Home telephone: Mobile telephone:

Work telephone: Email address:

Father or legal guardian - full name:

Home telephone: Mobile telephone:

Work telephone: Email address:

If parents or legal guardians are not available, please contact:
Name and relationship to student:

Home telephone: Mobile telephone:

Work telephone: Email address:

3. STUDENT'S MEDICAL HISTORY

This information will aid in making an accurate assessment in case of illness or emergency. Please check if the student has ever had the following:

❑ Anaphylatic episodes
❑ Anemia
❑ Asthma
❑ Birth defects
❑ Blood transfusions
❑ Chest pain
❑ Chicken pox
❑ Cough-persistent
❑ Diabetes
❑ Fatigue-unexplained
❑ Head/eyes/ears/throat problems
❑ Joint/muscle pain/stiffness
❑ Leukemia
❑ Measles
❑ Mumps
❑ Rheumatic fever
❑ Scarlet fever
❑ Seizures
❑ Shortness of breath
❑ Sleep problems
❑ Stomach/bowel problems
❑ Tuberculosis exposure
❑ Weight gain-unexplained
❑ Weight loss-unexplained

Please explain any checked items:

Medications take by the student on a regular basis:

Does the student have allergies to food, medications or environmental pollens? ❑ Yes ❑ No

If yes, please list:

Student's medical provider: Telephone:

Student's pharmacy: Telephone:

4. INSURANCE INFORMATION

Please complete the following insurance information for student. This information is required for student's health record to be complete but will only be billed if services are provided by King's Daughters. School nurse visits are not billed to insurance. Please fully complete and attach copy of insurance card.

PRIMARY POLICY

Insurance company: Policy number: Group Number:

Send medical claims to address on card:

Name on insurance card: Name of primary insured (policy holder):

Relationship to student: Policy holder's date of birth: / /

Social Security Number of primary insured (policy holder): - -

Policy holder's address:

City: State: Zip code:

SECONDARY POLICY

Do you have another health insurance policy that may provide additional coverage? ❑ Yes ❑ No

If yes, please provide information below.

Insurance company: Policy number: Group Number:

Send medical claims to address on card:

Name on insurance card: Name of secondary insured (policy holder):

Relationship to student: Policy holder's date of birth: / /

Social Security Number of secondary insured (policy holder): - -

Policy holder's address:

City: State: Zip code:

5. CONSENT AND PERMISSION

By my signature below, I hereby give consent for student to receive the following services from King's Daughters while at school:

1. Annual well visits
2. Physical/wellness exam
3. Sports physical exam
4. Acute visits
5. Lab draws
6. Point of care testing
7. Flu immunizations (the flu immunization and all other immunizations will require a separate consent)
8. Medication administration
9. Drug dispensing
10. Education
11. Telemedicine
12. COVID-19 testing

Would you like your child to have their yearly physical (wellness visit) with our provider while at school?..... ❑ Yes ❑ No

Are there services you definitely do not want your student to receive while at school?

_____

_____

Prior to providing any of the services above, KDMC or school will make a courtesy call to you and will accommodate, within reason, your request to be present when services are rendered. However, if we are unable to reach you, we will still provide services to student pursuant to this consent.

In addition, by my signature below, I hereby give permission as follows:

1. To King's Daughters to review student's school record, including attendance and other information, if applicable, that will assist in treating student;
2. On behalf of student to participate in ongoing evaluations administered by King's Daughters, including questionnaires and surveys;
3. To King's Daughters to disclose to appropriate school staff the medical information of student, as King's Daughters deems necessary;
4. To the following hospitals to release to King's Daughters student's emergency room reports: _____
5. To King's Daughters to disclose to any appropriate agencies or medical practitioner any medical and billing information that may result from student's contact with (include clinic name): _____
6. To King's Daughters to obtain any records or information from any agency or private professional regarding student's care.

_____ King's Daughters is released from all liability that may arise from the permissions granted in Section 5.
initial

At the end of this form, please provide an email address for an account that you regularly check. This will enable you to register for MyChart, an online service that will provide you with easy, confidential access to student's medical records.

By my signature below, I agree to provide King's Daughters with updated or additional information applicable to Sections 3 through 6 of this form, as necessary. This includes information related to the medications taken by student and the over-the-counter medications you wish student not to receive.

6. RELEASE OF INFORMATION FOR BILLING PURPOSES

By my signature below, I hereby authorize the release of student's medical information to applicable third-party payors, governmental agencies, and other organizations, as necessary for billing purposes only. Unless otherwise indicated, this authorization extends to such psychiatric, alcohol or drug abuse, and HIV-related diagnosis information, if any, as may be contained in student's records. I understand that I have the authority to release the above referenced medical records on behalf of student. This constitutes permission to release medical information regarding sexually transmitted diseases, if applicable, to third-party payors pursuant to KRS 214.420.

_____ King's Daughters is released from all liability that may arise from the permissions granted in this Section 6.
initial

7. PRIVACY AND ASSIGNMENT OF BENEFITS

This form has been fully explained to me. I have been given an opportunity to ask questions and am satisfied that I understand its content and significance. By my signature below, I agree that the information I've provided in this form is true and accurate to the best of my knowledge. I understand that King's Daughters shall provide a copy of their Notice of Privacy Practices upon my request, and that said Notice is also available at KingsDaughtersHealth.com. I also request payment of authorized medical insurance benefits be made to King's Daughters on student's behalf for services he/she receives. I realize I am responsible to pay for any non-covered services student receives and/or services requiring insurance authorization.

Date: _____

Signature of the parent/legal guardian: _____

Telephone: _____

Email: _____

King's Daughters

WALK-IN CARE FOR SCHOOLS
TELEMEDICINE INFORMED CONSENT
2023-2024 SCHOOL YEAR

STUDENT INFORMATION

Today's date: / /

Student name: Date of birth: / /

Introduction. In providing services to student at King's Daughters School Health Clinic ("School Health Clinic"), UK King's Daughters ("KDMC", "we" or "us") may occasionally utilize videoconferencing technology, also known as "telemedicine." Telemedicine may be used for diagnosis, therapy, follow-up and/or education. We are excited to offer this option as it allows improved access to care by enabling student to remain at school while obtaining services from our remote providers. In order to use telemedicine, student must have a separate consent for services form on file at school, completed and signed by student's parent or legal guardian.

Telemedicine procedure. When telemedicine is used, student will be in the company of a school nurse, school technician or employee of King's Daughters who is working that day. King's Daughters' remote provider will be located elsewhere. During the encounter, student and the remote provider will be able to see and hear each other as though they were in the same room. Telemedicine utilizes various safety measures to ensure the videoconference is secure, and that no part of the encounter will be recorded without your written consent.

Alternatively, if you are not comfortable with student receiving treatment via telemedicine, you may reject its use and schedule a face-to-face encounter at another time at the School Health Clinic.

Possible risks. The potential risks of telemedicine include, but are not be limited to:

- A provider may determine that the telemedicine encounter is not yielding sufficient information to make an appropriate clinical decision.
- Technology problems may delay medical evaluation and treatment for the encounter.
- Just as with other health information technology, security protocols could fail, causing a breach of privacy of personal medical information.

By signing this form, you are indicating that you understand the following:

1. The state and federal laws that protect the privacy, confidentiality, dissemination, storage and retention of individual health information also apply to a telemedicine consultation.
2. I have the right to access medical information resulting from student's telemedicine consultation at any time as provided by law.
3. I have the right to object to the video taping of student's telehealth consultation.
4. I have the right to seek an alternative to a telemedicine consultation in the form of a face-to-face encounter as set forth above.
5. No information obtained in the use of telemedicine that identifies student will be disclosed to researchers or other entities without my consent.
6. I have the right to be informed of the parties who will be present at the receiving end of student's telehealth transmission and who will be with student during the telemedicine consult (including equipment operators). I have the right to exclude anyone at either end of the transmission.
7. I understand that I have the option to refuse a telemedicine consultation on behalf of student at any time and that my refusal shall not affect student's right to future care or treatment nor affect student's right to health insurance benefits to which student is entitled.
8. I understand that if the provider believes that student would be better served by a traditional face-to-face encounter, the provider may at any time stop the telemedicine visit and schedule a face-to-face visit.
9. I understand that while I may expect certain benefits from the use of telemedicine in student's care, no results can be guaranteed or assured.

CONSENT TO THE USE OF TELEMEDICINE

I have read and understand the information provided above regarding telemedicine. I hereby give my informed consent on behalf of student for the use of telemedicine in student's treatment, if applicable, and consent to appropriate billing of my insurance, if applicable.

Parent/guardian name (printed): Relationship to student:

Parent/guardian signature: Date: Time:

FOR OFFICE USE

- A copy of this form was supplied to parent/guardian (or to student if applicable).

King's Daughters

Notice of Privacy Practices
Effective Date: 8/28/2023
Supersedes Policy: 7/12/16, 9/23/13, 6/27/13, 6/22/12, 10/1/09; 8/21/06, 4/14/03

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, please contact our Privacy Office at the address or phone number at the bottom of this notice.

Our pledge to you.

We understand that medical information about you is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive to provide quality care and to comply with legal requirements. This notice applies to all of the records of your care that we maintain, whether created by facility staff or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office. We are required by law to:

- Keep medical information about you private.
- Give you this notice of our legal duties and privacy practices with respect to medical information about you.
- Notify you following a breach of your unsecured medical information.
- Follow the terms of the notice that is currently in effect.
- Use or disclose your medical information in accordance with applicable law.

Who will follow this notice?

King's Daughters Medical Center and Kings Daughters Medical Center Ohio and their affiliates and subsidiaries ("KDMC") (collectively referred to as "we," "our," "us" or "King's Daughters") provide healthcare to our patients in partnership with physicians and other professionals and organizations. The information privacy practices in this notice will be followed by us and by:

- Any healthcare professional who treats you at any of our locations.
- All departments and units of our organization, including our Urgent Care Centers, Family Care Centers, and Home Health Agency.
- All Team Members, staff, and volunteers of our organization.
- All Kentucky and Ohio locations

Changes to this Notice.

We may change our policies at any time. Changes will apply to medical information we already hold, as well as new information after the change occurs. Before we make a significant change in our policies, we will change our notice and post the new notice in waiting areas and on our website at

www.kingsdaughtershealth.com. You can receive a copy of the current notice at any time. The effective date is listed at the top of the first page. You will also be asked to acknowledge in writing your receipt of this notice.

How we may use and disclose medical information about you.

- We may use and disclose medical information about you for treatment (such as sending medical information about you to a specialist as part of a referral or sharing your medical information with providers and staff at other health care facilities for care purposes); to obtain payment for treatment (such as sending billing information to your insurance company or Medicare); and to support our healthcare operations (such as comparing patient data to improve treatment methods sending medical information to a social services agency, home and community based services provider or other similar third party that provides health or human services to specific individuals for individual-level care coordination or case management).

- Medical Staff. Because King's Daughters is a clinically-integrated setting, our patients receive care from hospital staff and from independent practitioners on the medical staff. The hospital and its medical staff must be able to share your medical information as necessary for treatment, payment and health care operations as described above. Because of this, the hospital and all medical staff have entered into an Organized Health Care Arrangement, or OHCA, that allows the OHCA to use this notice as a joint notice for all treatment rendered at the hospital and to obtain a single acknowledgement of receipt of the notice.

- Health Information Exchanges. We participate in one or more Health Information Exchanges to facilitate the provision of health care. Unless you notify us otherwise, we may use and disclose medical information about you to participate in such Health Information Exchanges, as described more fully below.

We participate in the Kentucky Health Information Exchange. The Kentucky Health Information Exchange ("KHIE") makes patient health care information available electronically to the Kentucky Department of Medicaid Services, Kentucky State Laboratory and certain health care providers who are covered by HIPAA and participate in the KHIE ("KHIE Participants"). KHIE Participants agree to KHIE's terms and conditions, including its security and privacy requirements, and agree to access the information for purposes of treatment, payment and health care operations according to applicable federal and state laws. A detailed description of KHIE can be found at http://khie.ky.gov/PAGES/INDEX.ASPX. Making patient health care information available to participating health care providers through KHIE promotes efficient and quality health care for patients. We are a KHIE participant. As such, we are able to obtain more complete information about our patients' medical histories when their health care information is available through KHIE. We make our patients' health care information available to other KHIE Participants who have a need to know it for purposes of treatment, payment and health care operations. You may choose not to allow your information to be available through the KHIE by contacting the Privacy Officer. Participation in the KHIE is not a condition of receiving care. However, if you decide not to make your information available to the KHIE, it may limit the information available to your health care providers. Your information is not stored with the KHIE. Rather, information is only pulled through the KHIE when participating providers request your information. Then, a copy of your information is stored with the receiving provider, much like a fax between health care providers. Please let us know if you have questions about KHIE or desire not to make your information available through the KHIE.

We participate in the Ohio Health Information Exchange ("OHIE") which uses the CliniSync health information exchange technology to share health information electronically. Your healthcare providers use this electronic network to securely provide access to your health records for a better picture of your

health needs. We and other participating healthcare providers, may allow access to your health information through the OHIE for treatment, payment, or other healthcare operations. The OHIE follows federal and Ohio privacy laws. You may choose not to make your information available through the OHIE by providing written notice to us of your decision to opt-out. For instructions on how to opt-out, please contact our Privacy Officer listed below. Participation in the OHIE is not a condition of receiving care. However, if you decide to not make your information available to the OHIE, your medical information may not be available to your health care providers who search the OHIE for information to provide you treatment. Additional information on the OHIE can be found at www.clinisync.org by searching for Patient Choice. Please let us know if you have questions about the OHIE or desire not to make your information available through the OHIE.

- Data Registries. We may participate in data registries to support our health care operations (including quality improvement) or for payment, public health, research and other legitimate and permissible activities. We may use and disclose medical information about you to participate in such registries in accordance with applicable law.

Other reasons we may use or disclose your medical information.

We may use or disclose medical information about you without your prior authorization for several other reasons. These reasons include:

- **When required by law.** We may use or disclose your protected health information to the extent that the use or disclosure is required by state or federal law, including disclosures to the U.S. Department of Health and Human Services when the information is requested to show we are complying with federal privacy law. Uses or disclosures required by state or federal law 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.

- **For public health activities.** 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 for the purpose of preventing or controlling disease, injury or disability;
  - a public health authority or other governmental authority that is authorized by law to receive reports of child abuse or neglect;
  - a person subject to the jurisdiction of the Food and Drug Administration (FDA), for public health purposes related to the quality, safety or effectiveness of FDA-regulated products or activities such as collecting or reporting adverse events, dangerous products, and defects or problems with FDA-regulated products;
  - a person who may be at risk of contracting or spreading a disease, if such disclosure is authorized by law;
  - your employer, for the purposes of conducting an evaluation of medical surveillance of the workplace or for the purposes of evaluating whether you have a work-related illness or injury; or
  - your school or your child's school, if the information is limited to proof of immunization and the school is required by law to have such proof prior to admitting you or your child. We will obtain and document your agreement to such disclosures.

- **When we believe you to be a victim of abuse or neglect.** 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, if you do not agree

to the disclosure, the disclosure will be made consistent with the requirements of applicable federal and state laws, and only if required or authorized by law.

- **For health oversight activities**. We may disclose your 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, government benefit programs, other government regulatory programs and entities subject to the civil rights laws.

- **For judicial and administrative proceedings**. We may use or disclose your protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal, or in certain conditions in response to a subpoena, discovery request or other lawful process not accompanied by an order of a court or administrative tribunal.

- **For law enforcement purposes**. We may disclose your protected health information for a law enforcement purpose to a law enforcement official if certain conditions are met.

- **So that coroners, medical examiners, and funeral directors can carry out their duties**. We may disclose protected health information to a coroner or medical examiner for the purpose of identifying a deceased person, determining cause of death, or performing other duties authorized by law. We may also disclose protected health information to funeral directors, consistent with applicable law, where such information is necessary to carry out the funeral directors' duties with respect to the deceased.

- **To facilitate organ, eye, or tissue donation and transplantation**. We may disclose protected health information to organ procurement organizations or other similar entities for the purpose of facilitating organ, eye, or tissue donation and transplantation.

- **For research purposes**. We may use or disclose your protected health information for research purposes, if certain conditions are met.

- **To avert a serious threat to health or safety**. We may, consistent with applicable law and standards of ethical conduct, use or disclose protected health information if we believe that the use or disclosure is necessary to prevent or lessen a serious threat to the health or safety of a person or the public; provided that, if a disclosure is made, it must be to a person(s) reasonably able to prevent or lessen the threat. We may also use or disclose protected health information if we believe that the use or disclosure is necessary for law enforcement authorities to identify or apprehend an individual who: (i) admits to participation in a violent crime that we reasonably believe caused serious physical harm to the victim, or (ii) appears to have escaped from a correctional institution or lawful custody.

- **For military activities**. We may use or disclose protected health information of individuals who are Armed Forces personnel for activities deemed necessary to assure proper execution of the military mission, provided certain conditions are met. We may also use or disclose protected health information of individuals who are foreign military personnel to their appropriate foreign military authority for activities deemed necessary to assure proper execution of military missions, provided certain conditions are met.

- **For national security and intelligence activities**. We may disclose protected health information to authorized federal officials for the conduct of lawful intelligence, counter-intelligence, and other national security activities authorized by the National Security Act and implementing authority. We

may also disclose protected health information to authorized federal officials for the protection of the President or other persons, or for certain federal investigations.

- **For the information of correctional institutions or other law enforcement custodians**. Should you be an inmate of a correctional institution or be in the lawful custody of a law enforcement official, we may disclose your protected health information to the institution or the official if necessary for your health, the health and safety of other inmates or law enforcement, and the safety of the institution at which you reside. An inmate does not have the right to the Notice of Privacy Practices.

- **For workers' compensation purposes**. We may disclose your protected health information to the extent authorized by and to the extent necessary to comply with laws relating to workers' compensation or to other similar programs established by law.

- **To family or friends**. We may disclose protected health information about you to a friend, family member or other person designated by you who is involved in your medical care or payment for your care, to the extent the information is directly relevant to that person's involvement with your care.

- **For notification/disaster relief purposes**. We may use or disclose your protected health information to notify or assist in notifying a family member, personal representative or another person responsible for your care, about your location, general condition or death. We may also use protected health information or disclose such information to a disaster relief entity authorized by law or its charter to aid in disaster relief efforts, for the purpose of coordinating with such entities the notifications described above.

- **Deceased**. If you are deceased, we may disclose protected health information about you to a friend or family member who was involved in your medical care or the payment of your medical care prior to your death, limited to information relevant to that person's involvement, unless doing so would be inconsistent with wishes you expressed to us during your life.

- **Business Associates**. There are some services provided to us through contacts known as Business Associates. We will disclose your protected health information to our Business Associates, and allow them to create, use, maintain or transmit your information to perform their jobs for us. For example, we may disclose your protected health information to an outside billing company who assists us in billing insurance companies. To protect your information, however, we will seek assurances from the Business Associate that it has implemented appropriate safeguards to protect your information.

- **Facility Directory**. If you are admitted as a King's Daughters patient, unless you tell us otherwise, we will list in the patient directory your name, location in the hospital, your general condition (good, fair, etc.) and your religious affiliation, and will release all but your religious affiliation to anyone who asks about you by name. Your religious affiliation may be disclosed only to a clergy member. Being listed in the patient directory and other forms of releases may also be limited by state and federal law (see below).

- **Fundraising**. We raise funds to expand and support health care services, educational programs and research activities related to curing disease. Accordingly, we may use, or disclose to a Business Associate or the King's Daughters Health Foundation, the following information to contact you for our fundraising activities: your name, address, other contact information, age, gender and date of birth; the departments where you received services, your treating physician, your outcome information, your health insurance status, and the dates you received services. You have the right to opt out of receiving our fundraising communications. If you opt out of receiving our fundraising communications, you can always choose to opt back in with respect to specific campaigns or ask to

be contacted for our fundraising efforts by calling or emailing our Privacy Officer listed below. We do not condition treating you on your choice of whether to receive fundraising communications.

- **Patient Communications**. We may use or disclose your protected health information, including your email address, for appointment reminders, enrollment in the patient portal and other patient notification purposes. Such communications may be via texting, email, or the patient portal.

Authorization Required.

Certain uses and disclosures of your protected health information require that we obtain your prior authorization. These include:

- **Psychotherapy Notes**. If Psychotherapy Notes are created for your treatment, most uses and disclosures of these notes will require your prior written authorization. "Psychotherapy Notes" means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. "Psychotherapy Notes" excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

- **Marketing**. If we use or disclose your medical information for marketing purposes, we must first obtain your written authorization to do so, except if the communication is face-to-face by us to you, or is a promotional gift of nominal value.

- **Sale of your Medical Information**. If a disclosure of your medical information would constitute a sale of it, we must first obtain your written authorization to do so.

Special Restrictions on Sensitive Information.

- Special restrictions may apply under state or federal law for disclosures concerning certain sensitive information, such as information pertaining to mental health, substance abuse diagnosis or treatment, HIV/AIDS related testing and treatment, or sexually transmitted diseases. When these special restrictions apply to your health information, we will comply with the applicable law.

Other uses and disclosures of medical information.

- In any other situation not described in this notice, we are required to obtain your written authorization before using or disclosing your medical information. If you choose to authorize use or disclosure, you can later revoke that authorization by notifying us in writing of your decision. However, the revocation will not be effective (1) to the extent we took action in reliance on the authorization before receiving the revocation, or (2) if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Your rights regarding medical information about you.

- **Right to Inspect and Copy**. In most cases, you have the right to look at and to get a copy of your medical records and billing records that we maintain or that are maintained for us, when you submit a written request. If the information is maintained electronically and if you request an electronic copy,

we will provide you with an electronic copy in the form and format requested by you, if it is readily producible in that form or format (if it is not, then we will agree with you on a readable electronic form and format). You can direct us to transmit the copy directly to another person if you submit a signed written request to our Privacy Officer that identifies the person to whom you want the copy sent and where to send it. If you request copies, we may charge a reasonable cost-based fee for: (1) the labor involved in copying the information; (2) the supplies for creating the paper copy or the cost of the portable media; (3) postage when you request to receive the information by mail; and, (4) the labor involved in preparing a summary or explanation of your records, if you choose to receive a summary and you agree to the fees for preparing such summary in advance. If we deny your request to review or obtain a copy of your medical or billing records, you may submit a written request for a review of that decision.

- **Right to Amend**. If you believe that information in your medical or billing records is incorrect or if important information is missing, you have the right to request that we correct the records, by submitting a request in writing that provides your reason for requesting the amendment. We could deny your request to amend a record for a number of reasons, including: if the information was not created by us; if it is not part of the information maintained about you by or for us; or if we determine that record is accurate and complete. You may submit a written statement of disagreement with our decision not to amend a record.

- **Right to an Accounting**. You have the right to a list of those instances where we have disclosed medical information about you, except in the following instances: disclosures for treatment, payment and health care operations; disclosures made to you; disclosures incident to a use or disclosure permitted or required by the Federal HIPAA Privacy Rule; disclosures authorized by you; disclosures for our directory; disclosures to persons involved in your care or for other notification purposes, or to disaster relief authorities; disclosures for national security and intelligence purposes; disclosures to correctional institutions or other law enforcement custodians; disclosures that are part of a limited data set; and disclosures occurring more than six years prior to the date of your request. You must submit a written request to obtain the list of those instances where we have disclosed medical information about you. The request must state the time period desired for the accounting, which must be less than a six-year period from the date of the request. You may receive the list in paper or electronic form. The first disclosure list request in a 12-month period is free; other requests will be charged according to our cost of producing the list. We will inform you of the cost before you incur any costs.

- **Right to Request Restrictions**. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone involved in your care or the payment for your care, like a family member or a friend. For example, you could ask that we not use or disclose information about a surgery you had. We will inform you of our decision on your request. Requests should be submitted in writing to our Privacy Officer whose address is listed at the end of this notice. Unless otherwise required by law, we must comply with a request from you not to disclose your medical information to a health plan, if the purpose for the disclosure is not related to treatment, and the health care items or services to which the information applies (such as a genetic test) have been paid for out-of-pocket and in full; otherwise, we are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. Except for restrictions that we must comply with relating to health plans, we may terminate our agreement to a restriction at any time by notifying you in writing, but our termination will only apply to information created or received after we sent you the notice of termination, unless you agree to make the termination retroactive.

- **Right to a Paper Copy of this Notice.** You have the right to receive a paper copy of this notice upon request.

- **Right to Request Confidential Communications.** You have the right to request that medical information about you be communicated to you in a confidential manner, such as sending mail to an address other than your home, by notifying us in writing of the specific way or location for us to use to communicate with you.

All written requests or appeals should be submitted to our Privacy Office listed at the bottom of this notice.

Complaints.

- If you are concerned that your privacy rights may have been violated, or you disagree with a decision we made about access to your records, you may contact our Privacy Office (listed below):

Privacy Office and Contact
Privacy Officer
King's Daughters Medical Center
2201 Lexington Ave.
Ashland, KY 41101
Phone (606) 408-0161
PrivacyOfficer@kdmc.kdhs.us

- You may send a written complaint to the U.S. Department of Health and Human Services Office for Civil Rights. Our Privacy Officer can provide you the address or you can visit the Office for Civil Rights website at www.hhs.gov/ocr/privacy/hipaa/complaints.

- Under no circumstances will you be penalized or retaliated against for filing a complaint.

King's Daughters

Acknowledgement of Receipt of Notice of Privacy Practices

KING'S DAUGHTERS MEDICAL CENTER
2201 LEXINGTON AVE.
ASHLAND, KY 41101

Section A or Section B should be completed and this form placed in the medical record.

Section A

I, _____ (print name) acknowledge that I received the King's Daughters' ("King's Daughters") Notice of Privacy Practices.

_____ _____
Signature Date

Section B (to be completed by King's Daughters' personnel if patient or representative will not or cannot sign acknowledgement in Section A)

A good faith effort was made to explain the purpose and content of the King's Daughters' Notice of Privacy Practices to the patient or his/her representative and to obtain an acknowledgement from the patient or his/her representative that the Notice of Privacy Practices was received, but (check one):

☐ Patient or representative refused to sign.

☐ Patient was in an emergency treatment situation during first service delivery, and the Notice of Privacy Practices was provided as soon as was practicable after the emergency treatment situation passed.

☐ Other (list reason why acknowledgement not obtained):

_____

_____

_____

_____ _____
Signature Date