NOTICE REGARDING PRIVACY OF PERSONAL HEALTH INFORMATION

This document (the Agreement) contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment, and health care operations. The law requires that we obtain your signature acknowledging that we have provided you with this information. It is very important that you read the information carefully. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time.

GENERAL INFORMATION

Federal regulations developed under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), 45 C.F.R. Parts 160 & 164 require that Dixie State College provide you with this Notice regarding privacy of Personal Health Information (PHI).

HOW WE CAN USE HEALTH CARE INFORMATION

Federal law permits disclosure of information without your written permission in the following circumstances:

- Life endangerment
- To provide treatment to you
- To ensure appropriate payment for the treatment we provide
- To monitor the quality of our operations
- Pursuant to an agreement with a business associate
- For research, audit, or evaluations
- To report a crime committed on the agency premises or against agency personnel
- To provide medical personnel with necessary information in a medical emergency
- To report suspected abuse or neglect of a child, an elderly person or a disabled person to the appropriate authorities
- As allowed by court order

WHEN WE MAY DISCLOSE INFORMATION

In certain limited cases we are permitted to disclose health care information about you. Examples include when there is a serious threat to a person’s health or safety, to reduce public health risks, for health oversight, and in certain cases of law enforcement. In addition, we may disclose information to tell you about health related services and products.
YOUR INFORMATION RIGHTS

Our agency creates a record of the treatment we provide you. Under HIPAA you have the right to:

- Know how we use your health information, who we give it to, and your rights to the information.
- Request restriction on certain uses and disclosures of your health information where we believe such restrictions will not harm you and where it is possible to do so.
- Request that we communicate with you by alternative means or at an alternative location. For example, you can ask for a conversation to be held in private or for us to send a copy of your bill to a different address. Dixie State College will accommodate such requests that are reasonable and will not request an explanation from you.
- Get a copy of your own health information maintained by Dixie State College, unless your therapist has determined and indicated that this would be harmful to you or someone else.
- Right to request that your records be amended if we agree it is inaccurate or incomplete.
- Ask us for a list when we have disclosed your health information to someone other than those treating you, handling your bills, for our internal purposes, or those to whom you have authorized release of information.

If you believe that your privacy rights have been violated, you have the right to relate complaints to the staff at Dixie State College Health & Wellness Center or Dean of Students, and to the Secretary of the Department of Health and Human Services. You may provide complaints to any Dixie State College staff member of the Health & Wellness Center or Dean of Students, verbally or in writing.

Effective October 1, 2010

This is a summary of 45 CFR, Parts 160 & 164 (HIPAA). A complete copy of this Federal regulation can be found in the Federal Register as obtained from the Federal Government.

ACKNOWLEDGMENT

I hereby acknowledge receiving a copy of the Health Insurance Portability and Accountability Act of 1996 (“HIPPA”) notice of Privacy.

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Client Name (please Print)

__________________________  ________________________
Client Signature                  Date

__________________________  ________________________
Witness Signature                  Date