



# ROBLAND Home Healthcare Corporation

FORM 23000

## MINNESOTA PROVIDER NOTICE OF PRIVACY PRACTICES

EFFECTIVE DATE OF THIS NOTICE: \_\_\_\_\_

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**THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

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### **Our Pledge and Legal Duty To Protect Health Information About You.**

The privacy of your health information is important to us. We are required by federal and state laws to protect the privacy of your health information. We must give you notice of our legal duties and privacy practices concerning your health information, including:

- We must protect information that we have created or received about your past, present, or future health condition, health care we provide to you, or payment for your health care.
- We must notify you about how we protect your health information.
- We must explain how, when and why we use or disclose your health information.
- We may only use or disclose your health information as we have described in this Notice.
- We must abide by the terms of this Notice.

We are required to abide by the terms of this Notice. We reserve the right to change the terms of this Notice and to make new Notice provisions effective for all health information that we maintain. We will post a revised Notice in our offices, make copies available to you upon request and post the revised Notice on our website.

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## USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

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There are a number of purposes for which it may be necessary for us to use or disclose your health information. For some of these purposes, we are required to obtain your consent. In other specific instances, we may be required to obtain your individual authorization. And in a limited number of circumstances, we will be authorized by Law to disclose your health information without your consent or authorization. Following is a description of these uses and disclosures.

### **A. Uses and Disclosures of Your Health Information for Purposes of Treatment, Payment and Health Care Operations.**

- **Health Care Treatment.** We may use or disclose health information about you to provide and manage your health care. This may include communicating with other health care providers regarding your treatment and coordinating and managing the delivery of health services with others. For example, we may use or disclose health information about you when you need a prescription, lab work, an x-ray, or other health care services.
- **Appointment Reminders and Other Contacts.** We may use your health information to contact you with reminders about your appointments, alternative treatments you may want to consider, or other of our services that may be of interest to you.
- **Payment.** We may use or disclose your health information to bill and collect payment for the treatment and services provided to you. For example: A bill may be sent to you or a third party payer. The information on, or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.
- **Health Care Operations.** We may use or disclose health information about you to allow us to perform business functions. For example, we may use your health information to help us train new staff and conduct quality improvement activities. We may also disclose your information to consultants and other business associates who help us with these functions (for example, billing, computer support and transcription services).
- **Fundraising.** As part of our health care operations, we may use or disclose your demographic information and dates of treatment to contact you to raise money for our organization.

**Minnesota Patient Consent for Disclosures.**

For some of the disclosures of health information described above, we are required by Minnesota Laws to obtain a written consent from you, unless the disclosure is authorized by Law.

**B. Uses and Disclosures of Your Health Information that Require Your Opportunity to Agree or Object.**

In the following instances we will provide you with the opportunity to agree or object to our use or disclosure of your health information:

- **Facility Directory.** We may use or disclose your name, location in the facility, general condition, and religious affiliation for facility directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.
- **Persons Involved in Your Care.** We may, using our best judgment, disclose to a family member, other relative, close personal friend or any other person identified by you, health information relevant to that person's involvement in your care or payment related to your care.
- **Notification to Others.** We may, in some instances, disclose health information about you to a family member, a personal representative, or another person responsible for your care, in order to notify such person about your current location or general condition.

**C. Uses and Disclosures Authorized by Law.**

Under certain circumstances we are authorized by Law to use or disclose your health information without obtaining a consent or authorization from you. These may include when the use or disclosure is:

- **Required by Law.** We will disclose your health information when such disclosure is required by federal, state or local laws.
- **Necessary for public health activities.** For example, when reporting to public health authorities the exposure to certain communicable diseases or risks of contracting or spreading a disease or condition.
- **Related to victims of abuse and neglect.** For example, when reporting suspected victims of abuse or neglect.
- **For health oversight activities.** For example, when disclosing health information to a state or federal health oversight agency so that they can appropriately monitor the health care system.
- **For organ donation purposes.** For example when disclosing health information to an appropriate organization for the purpose of tissue donation and transplants.
- **For judicial and administrative proceedings.** For example, when responding to a request for health information contained in a court order.
- **For law enforcement purposes.** For example, when complying with laws that require the reporting of certain types of wounds or injuries.
- **To a Coroner of Medical Examiner.** To allow them to carry out their duties.
- **To avert a serious threat to health or safety.** For example, when disclosing health information that will help prevent a serious threat to the health or safety of you or another person of the public.
- **Related to specialized government functions.** For example, we may disclose health information about you if it relates to military and veterans' activities or national security.
- **Related to Workers' Compensation.** For example, when reporting health information to entities that provide benefits for work-related injuries and illness.
- **Related to correctional institutions.** And in other custody situations.

**D. Uses and Disclosures of Your Health Information that Require Your Authorization.**

Other uses and disclosures of your health information not covered in this Notice will be made only with your written authorization. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any uses or disclosures permitted by your authorization while it was in effect.

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**YOUR INDIVIDUAL RIGHTS**

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**A. Right to Access and Copy Your Health Information.**

You have the right to access and receive a copy or a summary of your health information contained in clinical, billing and other records that we maintain and use to make decisions about you. We ask that your request be made in writing. We may charge a reasonable fee. There might be limited situations in which we may deny your request. Under these situations, we will respond to you in writing, stating why we cannot grant your request and describing your rights to request a review of our denial.

**B. Right to Request an Amendment of Your Health Information.**

You have the right to request amendments to the health information about you that we maintain and use to make decisions about you. We ask that your request be made in writing and must explain, in as much detail as possible, your reason(s) for the amendment and, when appropriate, provide supporting documentation. Under limited circumstances we may deny your request. If we deny your request, we will respond to you in writing stating the reasons for the denial. You may file a statement of disagreement with us. You may also ask that any future disclosures of the health information under dispute include your requested amendment and our denial to your request.

**C. Right to Request Restrictions on Uses and Disclosures of Your Health Information.**

You have the right to request that we restrict our use or disclosure of your health information. We ask that your request be made in writing. We are not required to agree to your request for a restriction, and we will notify you of our decision. However, if we do agree, we will comply with our agreement, unless there is an emergency or we are otherwise required to use or disclose the information.

**D. Right to Request Confidential Communications.**

Periodically, we will contact you by phone, email, postcard reminders, or other means to the location identified in our records with appointment reminders, results of tests or other health information about you. You have the right to request that we communicate with you in a specific way or at a specific location. For example, you may request that we contact you at your work address or phone number or by email. We ask that your request be made in writing. While we are not required to agree with your request, we will make efforts to accommodate reasonable requests.

**E. Right to Request and Accounting of Disclosures of Health Information.**

You have the right to request a listing of certain disclosures we have made of your health information. We ask that your request be made in writing. You may ask for disclosures made up to six (6) years before the date of your request (not including disclosures made prior to April 14, 2003). We will provide you one accounting in any 12-month period free of charge.

**F. Right to Receive a Copy of This Notice.**

You have the right to request and receive a paper copy of this Notice at any time. We will make this Notice available in electronic form and post it in our web site.

If you have any questions about these rights or to exercise any of them please contact our Privacy Office listed below.

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**QUESTIONS OR COMPLAINTS**

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If you want more information about our privacy practices or have questions or concerns, please contact our Privacy Office. If you are concerned that your privacy rights have been violated, you may file a complaint with our Privacy Office. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

**Privacy Office Contact Information**

Address: 1500 1st Ave NE, Suite 210, Rochester, MN 55904

Phone: 507-252-4619 Fax: 866-597-0950 e-mail: robland@roblandhomehealth.com

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**ACKNOWLEDGEMENT OF RECEIPT**

*[For Organizations Choosing to Record Signature in the Notice]*

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**My signature below indicates that I have been provided with a copy of this Notice of Privacy Practices.**

\_\_\_\_\_  
**Signature of Patient/Client or Personal Representative**

\_\_\_\_\_  
**Date**

**If signed by personal representative, relationship to patient:** \_\_\_\_\_