This notice describes how information about you may be used and disclosed and how you can get access to this information.

Please Review Carefully

If you have any questions about this notice, please contact South Central Public Health District (SCPHD) Privacy Officer at 208-737-5936.

You may request a copy of this notice at any time. Copies of this notice are available at any District Health office. This notice is also available on the District website at www.phd5.idaho.gov.

Purpose of this Notice

This *Notice of Privacy Practices* describes how SCPHD handles confidential information, following state and federal requirements. All programs in the District may share your confidential information with each other as needed to provide you benefits or services, and for normal business purposes. The District may also share your confidential information with others outside of the District as needed to provide you benefits or services.

We are dedicated to protecting your confidential information. We create records of the benefits or services you receive from the District. We need these records to give you quality care and services. We also need these records to follow various local, state and federal laws.

We are required to:

- Use and disclose confidential information as required by law;
- Maintain the privacy of your information;
- Give you this notice of our legal duties and privacy practices for your information; and
- Follow the terms of the notice that is currently in effect.

This notice of privacy practices does not affect your eligibility for benefits or services

Your rights about your confidential information

1. **Rights to Review and Copy**
   - You have the right to ask to review and copy your information as allowed by law.
   - If you would like to review and copy your information, document your request in writing and deliver it to the District office. The District will respond to your request within 10 working days of receipt of your request. The District may extend the response time up to 10 additional working days if the information you have requested cannot be located within the original 10 days. You will be sent a notification of an extension and the reason for the extension.
   - If you ask to receive a copy of the information, we may charge a fee. If you request 100 pages or more from your file, the fee will be 5 cents per page.
   - You will be told if here is information we are legally prevented from disclosing to you.
2. **Right to Amend**
   - You have the right to ask us to make changes to your health information if you feel that the information we have about you is wrong or not complete.
   - If you would like to ask the District to change your health information, document your request in writing and deliver to the District office. The District will respond to your request within 20 working days.
   - We may deny your request if you ask us to change information that:
     Was not created by the District or is not part of the information kept by or for the District.
     Is not part of the information which you would be allowed to review and copy; or
     We determine is correct and complete
3. **Rights to Restrict Health Information Disclosures**
   - You have the right to ask us not to use or share your health information for your treatment or services, or normal business purposes. You must tell us what information you do not want us to use or share and whom we should not share it with.
   - If you would like to ask the District to not share your information, document your request in writing and deliver it to the District office. The District will respond to your request within 10 working days.
   - If we agree to your request, we will comply unless the information is needed to give you emergency treatment or until you end the restriction.
4. **Right to an Alternate Means of Delivery**
   - You have the right to ask that we deliver your information to you at a different mailing address or by a different method of communication.
   - If you would like to ask for an alternate means of delivery for your information, notify the program staff of SCPHD. We will not ask you the reason for your request,
   - All reasonable requests will be approved.
5. **Right to a Report of Health Information Disclosures**
   - You have the right to ask for a report of the disclosures of your health information. This report of disclosures will not include when we have shared your health information for treatment, payment for your treatment, or normal business purposes, or times you authorized us to share your information.
   - If you would like to request a report of your health information disclosures, document your request in writing and deliver it to the District office. The District will respond to your request within 20 working days.
   - The first report requested within a calendar year will be free of charge. For each additional report within the same calendar year, we may charge you for the costs of providing the report. We will tell you the cost and you may choose to remove or change your request at that time before any costs are incurred.

How the District may use and share your information

Times when your permission is not needed:
For Treatment: We may use your information to give you benefits, treatments or services. We may share your information with a nurse, medical professional or other personnel who are giving you treatment or services. The programs of SCPHD may also share your information in order to bring together the services that you may need. We also may share your information with people outside of the District who are involved in your care, such as family member, informal or legal representatives, or others that give your services as part of your care.

For Payment: We may use and share your information so that the treatment and services you receive through the District can be paid. For example; we may need to give your medical insurance company information about the treatment or services that you received so that your medical insurance can pay for the treatment or services.

For Business Operations: We may use and share your information for business operational purposes. This is necessary for the daily operation of the District and to make sure that all of our clients receive quality care. For example; we may use your information to review how well our staff provides services to you.

For Individuals Who are a Part of Your Care or Who Make Payments for Your Care: We may give your information to a family member, legal representative, or someone you designate who is part of your care. We may also give your information to someone who helps pay for your care. If you are unable to agree to such a release, we may share such information as needed if we determine that it is in your best interest based on our professional opinion. Also, we may share your information in a disaster to that your family or legal representative can be told about your condition, status and location.

Other uses and sharing of your information that may be made without your permission

- For appointment reminders
- For Treatment options
- As Required by law
- For Public Health Risks
- To Law Enforcement
- For Lawsuits and Disputes
- For Coroners, Medical Examiners, Funeral Directors
- For Organ and Tissue Donation
- For Emergency Treatment
- To Prevent a Serious Threats to Health and Safety
- To Military and Veterans organizations
- For Health Oversight Activities
- For National Security and Intelligence Activities
- To Correctional Institutions
- For IRIS (Immunization Registry)

Times when your permission is needed:

For reasons other than Treatment, Payment or Business Operations:
There may be times when the District needs to use and share your information for reasons other than for treatment, payment and business operations as explained above. For example; if the District is asked for information from your employer or school that is not part of treatment, payment or business operations, the District will ask you for a written consent permitting us to share that information. If you give us permission to use or share your information, you may stop that permission at any time if it is in writing. If you stop your permission, we will no longer use or share that information. You must understand that we are unable to take back any information already shared with your permission.

Change of Notice

SCPHD has the right to change this notice. A copy of this notice is posted at all of our District offices. The effective date of this notice is shown at the bottom of the page. If the District makes any changes to this *Notice of Privacy Practices*, the District will follow the terms of the notice that are currently in effect.

Complaints

If you believe your information privacy rights have been violated, you may file a written complaint with SCPHD. All complaints turned into the District must be in writing and submitted to the District office. To file a complaint with the District, send your completed Privacy Complaint form to:

South Central Public Health District
Privacy Officer
1020 Washington St N
Twin Falls, ID 83301-3156

If you believe your health information privacy rights have been violated, you may also file a complaint with the Secretary of Health and Human Services. Your complaint must be in writing and you must name the organization that is the subject of your complaint and describe what you believe was violated. Send your written complaint to:

Secretary of Health and Human Services
200 Independence Ave SW
Washington DC 20201

A complaint filed with either SCPHD or the Secretary of Health and Human Services must be filed within 180 days of when you believe the privacy violation occurred. This time limit for filing complaints may be waived for good cause.

You will not be punished or retaliated against for filing a complaint.

By signing below, I acknowledge that:
I have been given the opportunity to read SCPHD's Notice of Privacy Practices.

I have read the Financial Consent. I understand and agree to this policy. I also understand that I will be responsible for payment for all services. I authorize release of medical information necessary to process medical claims and authorize payment of benefits to SCPHD.

I have been offered copies (electronic and/or paper) of the Vaccine Information Statements for vaccines given today.
I understand that vaccines are not mandatory and may be refused for religious and/or other grounds.
I understand the benefits, risks, or complications from vaccines. (Further information about the vaccines being offered is available upon request).
I understand that all immunization records will be entered into the IRIS (Immunization Reminder Information System). Participation in the immunization registry is voluntary. To have your records removed from IRIS, you must contact the Idaho Immunization Program.
I consent for this child to receive capillary lead screening and/or hemoglobin screening if requested.
I consent, if scheduled to receive services through SCPHD Tuberculosis Clinic or Women's Healthcheck Program.

_____
Signature of client/ Parent or Legal Guardian

FINANCIAL CONSENT

The goal of our clinic is to provide you with quality health care at a reasonable cost. South Central Public Health District (SCPHD) is not a free clinic. A limited number of fees are available on a sliding scale based upon income and family size. In order to remain affordable, we depend upon you to make prompt payment for services and supplies. In an effort to do this, we have implemented a Financial Policy. This Financial Policy shares responsibility among all our clients.

FINANCIAL POLICY

The following is the Financial Policy, which we require you to read and sign prior to treatment. Full payment is due at time of service (including medications).

Exception: we offer a payment plan with prior approval.

We accept cash, checks, and credit cards.
Donations are appreciated for all services.
No one receiving Vaccine for Children (VFC) vaccines will be denied services due to inability to pay.
Your account balance does not affect your ability to continue receiving services.
Your account may be turned over to a collection agency if no payment is received within 120 days after an agency billing.
We may adjust your account balance to correct any billing errors found after the time of service.

REGARDING INSURANCE:

All clients must complete a Financial Request Consent before receiving services. Please present your insurance/Medicaid/Medicare card at the reception desk.
SCPHD will bill your insurance company for you, and the payment may come directly to SCPHD;.
You may use our services, but we recommend you check with your insurance company regarding coverage.
SCPHD may not be considered an In-Network provider and therefore cannot guarantee coverage by your insurance company.
Whether your insurance company pays or not, your account balance is your responsibility.
Some, and perhaps all, of the services provided may be non-covered services.
Confidentiality cannot be guaranteed with insurance billing.
Your insurance provider may send information to the holder of the insurance policy (who may be your parent, guardian, or spouse).