SUMMIT COMMUNITY CARE CLINIC-NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATON. PLEASE REVIEW IT CAREFULLY. Effective Date: 7-29-14

Your health information is personal, and Summit Community Care Clinic is committed to protecting it. Your health information is also an important part of our ability to provide you with quality care, and to comply with certain laws. These privacy practices are in compliance with HIPAA and HITECH regulations, which pertain to the use of private health information in written, oral and electronic formats. These privacy practices will serve as authority to access and share your health information as outlined by the terms of this notice as used by Summit Community Care Clinic to provide you with the best health care possible.

I. Understanding Your Health Information

Each time you visit Summit Community Care Clinic, an electronic record of your visit is created. This record usually contains your name and other information that may identify you, your symptoms, examination and test results, diagnoses, medications, treatment, plan for future health care, and financial information. This record is sometimes referred to as your "health record" and allows: Medical, dental and behavioral health providers to plan your treatment; Summit Community Care Clinic to obtain payment for services we provide to you; and Summit Community Care Clinic to measure the quality of care provided to you. We are committed to keeping your health information confidential. We will not use, or give to others, your health information without your written permission, except as stated in this notice.

II. How We Will Use and Give Out Your Health Information

a. Treatment, Payment, and Health Care Operations

We will use and give out your health information to provide you with health care treatments, to get paid for our services, and to help us operate our community health center. For example: We will give your health information, in verbal, written or electronic formats, to health care professionals, not on our staff, such as other doctors, pharmacies and hospital staff, who help care for you; we may bill you or a third party for services; we may use your health record to review our performance and make sure you receive quality health care.

b. Other Uses and Disclosures Allowed or Required by Law

Additional Uses and Disclosures that DO NOT Require Your Written Authorization: Public health activities, disclosures about victims of abuse, neglect or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, information about deceased persons, organ, eye or tissue donation purposes, research purposes, to avert a serious threat to health or safety, specialized government functions, workers' compensation and when required by law.

c. Other Uses and Disclosures Requiring Your Written Permission

For some types of health information, there may be stricter restrictions on our use or disclosure. For example, drug and alcohol abuse patient treatment information, HIV test results, mental health information, and genetic testing results may be subject to greater protection of your privacy. In general, we may disclose a minor patient's health information to a parent or guardian, but we may deny the parents' access to the minor patient's health information in some situations which are bound by stricter privacy laws.

Except as stated above, we will use or give out your health information only after getting your written permission on an Authorization/Records Request Form. You may revoke your authorization at any time by notifying us in writing that you wish to do so.

III. Your Rights Regarding Your Health Information

Subject to certain legal limits, you have rights regarding the use and disclosure of your health information, including the rights to: Request limits on uses of your health information, receive confidential communications of your health information, inspect and copy your health information, request a change to your health information, receive a record of how we have used and given out your health information, restrict disclosures to health plans, and obtain a paper copy of this Notice of Privacy Practices.

IV. CORHIO and Health Information Exchange

As a patient of SCCC, your health information is automatically entered into an electronic exchange that is accessible by other health care providers. This results in better care because other providers can see your health history and treat you more effectively. You have the choice to opt-out of the electronic exchange, and also have the option of opting-in again if you change your mind. Please see the front desk staff for more information. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

Questions, Concerns, and Changes to this Notice

If you have any questions or want to talk about any of the information in this Notice of Privacy Practices, please contact the Privacy Officer at the Summit Community Care Clinic at 668-4040.

If you believe your privacy rights have been violated, you may file a complaint with Summit Community Care Clinic, or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. **We will not retaliate against you for filing a complaint.**

We may change our Notice of Privacy Practices in the future. Such changes will apply to your health information that we created or received before the effective date of the change. We will notify you of any changes to our Notice of Privacy Practices by posting the changed notice at Summit Community Care Clinic and on our website.

I have received, read, and understand the Summit Community Care Clinic Notice of Privacy Practices

Patient Name: _____

Patient Signature:_____ **Date:**_____