NOTICE OF HIPAA PRIVACY POLICY FOR THE OAK POINT DEPARTMENT OF PUBLIC SAFETY

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

Who will follow this notice?

The Oak Point Department of Public Safety (the "Department") provides health care to our patients, residents, and clients in partnership with EMS professionals, physicians and other professionals and organizations. The information privacy practices in this notice will be followed by:

Any paramedic or health care professional employed or contracted by the Department who treats you.

All employed associates, staff or volunteers of our organization working in the Department.

Any business associate or partner of City of Oak Point with whom we share health information.

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 paramedics, 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.
- Follow the terms of the notice that are currently in effect.

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. We will notify you if we make a significant change in our policies before we treat you. The effective date of the notice is listed just below the title. You will be offered a copy of the current notice each time you are treated by our organization. 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, to obtain payment for treatment (such as sending billing information to your insurance company or Medicare), and to support our health care operations (i.e., comparing patient data to improve treatment methods.)

We may use or disclose medical information about you without your prior authorization for several other reasons. Subject to certain requirements, we may give out medical information about you without prior authorization for public health purposes, abuse or neglect reporting, health oversight audits or inspections, research studies, funeral arrangements and organ donation, workers' compensation purposes, and emergencies. We also disclose medical information when required by law, such as in response to a request from law enforcement in specific circumstances, or in response to valid judicial or administrative orders. We may disclose medical information about you to a friend or family member who is involved in your medical care, or to disaster relief authorities so that your family can be notified of your location and condition.

Other uses of medical information

In any other situation not covered by this notice, we will ask for your written authorization before using or disclosing medical information about you. If you chose to authorize use or disclosure, you can later revoke that authorization by notifying us in writing of your decision.

Your rights regarding medical information about you

In most cases, you have the right to look at or get a copy of medical information that we use to make decisions about your care when you submit a written request. If you request copies, we may charge a fee for the cost of copying, mailing or other related supplies. If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision.

If you believe that information in your record 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 if the information was not created by us, if it is not part of the medical information maintained by us, or if we determine that record is accurate. You may appeal, in writing, a decision by us not to amend a record.

You have the right to a list of those instances where we have disclosed medical information about you, other than for treatment, payment, health care operations or where you specifically authorized a disclosure, when you submit a written request. The request must state the time period desired for the accounting, which must be less than a 6-year period and

starting after April 14, 2003. 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 we process your request.
If this notice was sent to you electronically, you have the right to a paper copy of this notice.
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.
You may request, in writing, that we not use or disclose medical information about you for treatment, payment or healthcare operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. We will consider your request but we are not legally required to accept it. We will inform you of our decision on your request.
All written requests or appeals should be submitted to the Director of Public Safety 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 office at 972-294-0000. You may also send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights. Under no circumstance will you be penalized or retaliated against for filing a complaint.

Oak Point Department of Public Safety
Atten: Director of Public Safety-HIPPA Request
100 Naylor Rd.
Oak Point, Texas 75068

"HIPAA" Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:
- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand the "HIPAA PRIVACY POLICY" containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its "HIPAA PRIVACY POLICY" from time to time and that I may contact this organization at any time at the address supplied to obtain a current copy of the "HIPAA PRIVACY POLICY".
I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ______________________________

Relationship to Patient: ______________________________

Signature/ Date: ______________________________

OFFICIAL USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this "HIPAA PRIVACY POLICY" acknowledgement, but was unable to do so as documented below.

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Date Initials/Employee # Reason