

and include an explanation of your reason(s) for the amendment. The request must be submitted on the proper form to the Health Information Management or Clinic Manager where you received treatment.

- **Right to an Accounting of Disclosures**

You have the right to request an Accounting of Disclosures. This Accounting of Disclosures report does not include disclosures made for your treatment, payment, or health care operations. It also does not include disclosures made to or requested by you, or that you authorized.

You must submit your request for a report in writing to the Health Information Management or the Clinic Manager where you received care. Your request must state a time period, which is limited to the previous six years from the date of the request. The first request for an accounting of disclosures will be provided free of charge. We may charge you for additional report requests made within a 12 month period.

- **Right to Request Restrictions**

You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. If we agree with your request, we will comply unless the information is needed to provide emergency treatment, is required by law, or otherwise required to be disclosed as listed in this notice.

You must make your request for restrictions in writing to either the UF Health Shands Privacy Office or the UF Privacy Office. Your request must include what information you want to limit and how you want the limits to apply.

You have the right to restrict disclosures of health information made to a health plan when the items or services were paid in full prior to being rendered. Certain limitations apply.

- **Right to Choose How We Communicate With You**

You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example:

you can ask that we only contact you at work or by mail. You must make your request for alternate communications in writing to the Admissions supervisor at UF Health Shands, or to the UF Clinic Managers or supervisors. We will not ask you the reason for your request and will accommodate reasonable requests.

- **Right to a Paper Copy of This Notice**

You have the right to receive a copy of this notice from UF Health Shands or any UF clinic. You may obtain an electronic copy of this notice from our websites at: <https://ufhealth.org/patient-care> or www.privacy.health.ufl.edu.

- **Right to Breach Notification**

You have the right to and will receive notification in the event of a breach of your unsecured protected health information, unless such notification is exempted by law.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us. You will not be penalized or denied services for filing a complaint. To file a privacy complaint with UF Health Shands, please contact the Privacy Office, at, P.O. Box 103175, Gainesville, FL 32610-3175, or call 1-866- 682-2372. To file a privacy complaint with the UFHSC or UF Clinics, please contact the UF Privacy Office at P.O. Box 113210, Gainesville, FL 32611 or call 1-866-876-4472. All complaints must be submitted in writing on the appropriate form that is available on our website: www.privacy.health.ufl.edu. To file a complaint with the Secretary of the Department of Health and Human Services, visit the Office for Civil Rights website at www.hhs.gov/ocr.

*The University of Florida clinics and physicians' offices; the Florida Clinical Practice Association; the University of Florida Jacksonville Physicians, Inc., the University of Florida Jacksonville Healthcare, Inc.; the University of Florida Colleges of Medicine, Nursing, Health Professions, Dentistry and Pharmacy; the University Proton Therapy Institute; and other affiliated health care providers, including all employees, volunteers, staff and other University of Florida health services staff.



JOINT NOTICE OF PRIVACY PRACTICES AND NOTICE OF ORGANIZED HEALTH CARE ARRANGEMENT

Effective Date: September 23, 2013

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

If you have any questions about this Notice, please contact either the Privacy Office for UF Health Shands or the Privacy Office for the University of Florida at the contact information listed below:

UF Health Shands Privacy Office 1-866-682-2372
University of Florida Privacy Office 1-866-876-4472

OUR LEGAL DUTY TO PROTECT HEALTH INFORMATION ABOUT YOU

We understand your health information is personal and we are committed to protecting it. We create a record of the care and services you receive at UF Health Shands or the University of Florida Health Science Center (UFHSC) to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by UF Health Shands and/or the UFHSC, whether made by hospital personnel, University of Florida faculty, staff, students, or your personal doctor. This Notice describes how we may use and disclose your health information, and provides examples where necessary. This Notice also describes your rights regarding your health information.

We are required by law to maintain the privacy of health information, to provide individuals with notice of our legal duties and privacy practices with respect to health information, and to abide by the terms of the notice currently in effect.

CHANGES TO THIS NOTICE

We reserve the right to change our privacy practices and this notice at any time. We reserve the right to make the revised notice effective for health information we already have about you as well as any information we receive in the future. We will post a

copy of the current notice at all our facilities.

NOTICE OF ORGANIZED HEALTH CARE ARRANGEMENT

UF Health Shands, which for the purposes of this notice includes Shands Teaching Hospital and Clinics, Inc. and Shands Jacksonville Medical Center, Inc., and the UFHSC, together with the UFHSC clinics* and other affiliated health care providers have agreed as permitted by law, to share your health information among themselves for purposes of treatment, payment or health care operations. This arrangement enables us to better address your health care needs in the integrated setting found within UF Health Shands and the University of Florida health care providers.

The organizations participating in the Joint Notice are participating only for the purposes of providing this Joint Notice and sharing medical information as permitted by applicable law. These organizations are not in any way providing health care services mutually or on each other's behalf. UF Health Shands and the University of Florida are separate health care providers and each is individually responsible for its own activities, including compliance with privacy laws, and all health care services it provides.

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CONSISTENT WITH STATE AND FEDERAL LAW, WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION WITHOUT YOUR WRITTEN PERMISSION IN THE FOLLOWING CIRCUMSTANCES:

We may use and disclose your health information to **provide medical treatment to you and to coordinate or manage your health care and related services.** This may include communicating with other health care providers regarding your treatment and coordinating and managing your health care with others. For example: we may use and disclose your health information when you need lab work or an x-ray. Also, we may use and disclose your health information when referring you to another health care provider or to recommend treatment alternatives to you.

We may use and disclose your health information to **bill and receive payment for services rendered.** For example: A bill may be sent to you or your insurance company. The items on, or accompanying, the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used so that your health plan will pay the medical bill. We may also tell your health plan about a treatment you are expected to receive in order to obtain prior approval or to determine if your health plan will pay for that treatment.

We may use and disclose your health information for **health care operations.** We will use your health information for regular operations of the hospital and clinics to provide patients with quality care. For example: Members of the medical staff, the risk management team or the quality improvement team, including Patient Safety Organizations (PSOs), may use information in your health record to assess the care you receive and the outcomes of your treatment. We may also disclose information to doctors, nurses, technicians, medical students and other UFHSC personnel for review and teaching purposes.

We may also use and disclose your health information:

- When necessary to **prevent a serious threat to your health and safety** or the health and safety of the public or another person.
- To **organizations that facilitate donation and transplantation** of tissues and/or organs.

- To **authorized officials** when required by **federal, state, or local law.**
- In response to a **subpoena, court, or other administrative order.**
- As required by law, for **public health activities.** For example: preventing or controlling disease, reporting births and deaths, and reporting abuse and neglect.
- For authorized **Worker’s Compensation activities.**
- To **health oversight agencies.** For example: agencies that enforce compliance with licensure or accreditation requirements.
- To **coroners, medical examiners, or funeral directors** to carry out their duties.
- As required by **military command authorities,** if you are a member of the armed forces.
- To our **business associates** to carry out treatment, payment, or health care operations on our behalf. For example: we may disclose health information about you to a company who bills insurance companies for our services.
- For **research or to collect information in databases** to be used later for research. All research projects are reviewed and approved by an independent review board to protect the privacy of your health information.
- To a **correctional institution having lawful custody of you** as necessary for your health and the safety of others.

We may also use and disclose your information for **fundraising activities** to raise money for UF Health Shands or the UFHSC and their operations. If you do not want to be contacted for fundraising efforts, you must notify either the UF Health Shands Privacy Office or the University of Florida Privacy Office.

SPECIAL CIRCUMSTANCES

Alcohol, Drug Abuse, Psychotherapy Notes, and Psychiatric Treatment Information may have special privacy protections. We will not disclose any health information identifying an individual as a patient or provide information relating to the patient’s substance abuse or psychiatric treatment unless:

1. You or your personal representative consents in writing;

2. A court order requires disclosure;
3. Medical personnel need information to treat you in a medical emergency;
4. Qualified personnel use the information for research or operations activities;
5. It is necessary to report a crime or a threat to commit a crime; or
6. To report abuse or neglect as required by law.

YOU MAY REFUSE TO PERMIT CERTAIN USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

Unless you object, we may use or disclose your health information in the following circumstances:

- **Hospital Directories.** We may share your name, room number, and condition in our patient listing with clergy and with people who ask for you by name. We also may share your religious affiliation with clergy.
- **Individuals Involved in Your Care or Payment for Your Care.** We may use or disclose information to a family member, legal representative, or other persons involved with or responsible for your care or the payment of your care.
- **Emergency Circumstances and Disaster Relief.** We may disclose information about you to an agency assisting in a disaster relief effort so that your family can be notified of your location and general condition. Even if you object, we may still share the health information about you, if necessary for emergency circumstances.

USES AND DISCLOSURES OF HEALTH INFORMATION THAT REQUIRE YOUR WRITTEN PERMISSION

Other uses and disclosures of health information not covered by this notice or applicable law will be made only with your written permission. If you provide permission to use or disclose health information, you may revoke that permission at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your revocation. We are unable to take back any disclosures already made with your permission. We will not use or disclose your protected health information for marketing purposes, nor will we

sell your protected health information without your written permission.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights regarding health information we maintain about you:

- **Right to See and Obtain Copies of your Health Information**

You have the right to see and obtain copies of health information used to make decisions about your care. Usually, this includes medical and billing records, and excludes psychotherapy notes.

To view and copy your health information, you must submit your written request on the appropriate form to Health Information Management or the Clinic Manager. We may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to see and obtain copies of your health information in certain very limited circumstances. You have the right to appeal the denial.

- **Right to Amend**

If you think that your health and billing information is incorrect or incomplete, you may ask us to correct it. We may deny your request if:

- 1) The information was not created by us;
- 2) The information is not part of the records used to make decisions about your care;
- 3) We believe the information is correct and complete; or
- 4) You do not have the right to review parts of the medical record under certain circumstances.

We will tell you in writing the reasons for the denial and describe your rights to give us a written statement disagreeing with the denial.

If we accept your request to amend the information, we will make reasonable efforts to inform others of the amendment, as needed, including persons you name who have received information about you and who need the amendment. Your request must be in writing

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