



# Saint Louis University

## Notice of Privacy Practices

Effective Date: April 14, 2003

Amended: September 22, 2013

**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 any questions about this Notice please contact the SLU Privacy Officer at 314-977-5545 or e-mail [hipaa@slu.edu](mailto:hipaa@slu.edu)**

This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). It describes how we may use and disclose your protected health information, with whom it may be shared, and the safeguards we have in place to protect it. This notice also describes your rights to access and amend your protected health information.

### **ACKNOWLEDGMENT OF RECEIPT OF THIS NOTICE**

You will be asked to provide a signed acknowledgment of receipt of this notice. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care services will in no way be conditioned upon your signed acknowledgment. If you decline to provide a signed acknowledgment, we will continue to provide your treatment, and will use and disclose your protected health information for treatment, payment and health care operations when necessary.

### **OUR DUTIES TO YOU REGARDING PROTECTED HEALTH INFORMATION**

“Protected health information” consists of all individually identifiable information. This information includes demographics, for example, name, address, e-mail address, and relates to your past, present or future physical or mental health or condition and related health care services. Saint Louis University is required by law to do the following:

- Make sure that your protected health information is kept private.
- Give you this notice of our legal duties and privacy practices related to the use and disclosure of your protected health information.
- Notify you in the case of a breach of your identifiable medical information.
- Follow the terms of the notice currently in effect.

We may change the terms of our notice in the future. Upon your request, we will provide you with a revised Notice of Privacy Practices at our website: <http://www.slu.edu>, by calling 314-977-4440 and requesting that a revised copy be sent to you in the mail, or asking for one at the time of your next appointment.

### **HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION**

Following are examples of the types of uses and disclosures of your protected health care information.

### **USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION THAT DO NOT REQUIRE YOUR PERMISSION**

By law, we must disclose your health information to you unless it has been determined by a competent medical authority that it would be harmful to you. We must also disclose health information to the Secretary of the Department of Health and Human Services (DHHS) for investigations or determinations of our compliance with laws on the protection of your health information.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing and fundraising activities, and conducting or arranging for other healthcare related activities. For example, we may disclose your protected health information to medical and allied health school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information to contact you to remind you of your appointment. We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. Your name and address may be used to send you a newsletter about our practice and the services we offer. We may use or disclose your demographic information, the physicians who furnished the services, and the location and dates that you received treatment in order to contact you for fundraising activities supported by our office. You have the right to opt out of these fundraising communications, as described in every fundraising communication.

**Required By Law:** We may use or disclose your protected health information if the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

**Public Health:** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

**Communicable Diseases:** We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

**Health Oversight:** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

**Food and Drug Administration:** We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products, enable product recalls, make repairs or replacements, or to conduct post marketing surveillance, as required.

**Legal Proceedings:** We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

**Law Enforcement:** We may also disclose protected health information for law enforcement purposes. These law enforcement purposes include (1) responses to legal proceedings, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergencies (not on SLU premises) believed to result from criminal conduct.

**Coroners, Funeral Directors, and Organ Donation:** We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

**Research:** We may disclose your protected health information to researchers if an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information has approved the research.

**Criminal Activity:** Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

**Military Activity and National Security:** When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits; or (3) to foreign military authority if you are a member of that foreign military service. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others.

**Workers' Compensation:** Your protected health information may be disclosed as authorized to comply with workers' compensation laws and other similar legally established programs.

**Inmates:** We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

**Parental Access:** Some state laws concerning minors permit or require disclosure of protected health information to parents, guardians, and persons acting in a similar legal status. We will act consistently with the law of the state where the treatment is provided and will make disclosures following such laws.

## **USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION REQUIRING YOUR PERMISSION**

We will obtain your authorization to use or disclose your psychotherapy notes, other than for uses permitted by law without your authorization. Any other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgement, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed. In some instances you have the opportunity to agree or to object to the use or disclosure of all or part of your protected health information. Following are examples in which your agreement or objection is required.

**Others Involved in Your Healthcare:** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. We may also give information to someone who helps pay for your care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

**Emergencies:** We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your physician or another physician in the practice is required by law to treat you and the physician has attempted to obtain your consent but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

**Communication Barriers:** We may use and disclose your protected health information if your physician or another physician in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the physician determines, using professional judgement, that you intend to consent to use or disclosure under the circumstances.

## **YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION**

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

**You Have The Right To Inspect And Copy Your Protected Health Information:** You may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. If you request a copy of information (paper or electronic), we will charge a fee for the costs of copying, mailing or other supplies associated with your request. A designated record set contains medical and billing records and any other records that your physician and the practice use for making decisions about you. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be made. You may have a right to have this decision reviewed. Please contact our Medical Records Department if you have questions about access to your medical record.

**You Have The Right To Request Restrictions Of Your Protected Health Information:** You may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care. Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. You may revoke a previously agreed upon restriction, at any time, in writing.

**You Have The Right To Request That Health Information Pertaining to Services Paid Out of Pocket Not Be Sent to Insurance:** In some instance, you may choose to pay for a healthcare item or service out of pocket, rather than submit a claim to your insurance company. You have the right to request that we not submit your health information to a health plan or your insurance company, if you, or someone on your behalf, pay for the treatment or service out of pocket in full. To request this restriction, you must make your request in writing on the required form prior to the treatment or service.

**You Have The Right To Request To Receive Confidential Communications:** You may request that we communicate with you using alternative means or at an alternative location. We will accommodate reasonable requests, when possible. Please make this request in writing to our Privacy Officer.

**You Have The Right To Request An Amendment:** If you believe that the information we have about you is incorrect or incomplete, you may request an amendment to your protected health information as long as we maintain this information. While we will accept requests for amendment, we are not required to agree to the amendment or obligated to make any change to your record.

**You Have The Right To Receive An Accounting Of Disclosures:** You may request that we provide you with an accounting of the disclosures we have made of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. This disclosure must have been made after April 14, 2003, and no more than 6 years from the date of request. This right excludes disclosures made to you, to family members or friends involved in your care, or for notification. The right to receive this information is subject to certain exceptions, restrictions and limitations.

**You Have The Right To Obtain A Paper Copy Of This Notice:** You may obtain a paper copy of this notice from us or view it electronically at our website at [www.slu.edu](http://www.slu.edu)

## **COMPLAINTS**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Helpline of your complaint. We will not retaliate against you for filing a complaint. You may contact the Privacy Helpline at 877-525-5669, e-mail the Privacy Officer at [hipaa@slu.edu](mailto:hipaa@slu.edu), or write to the Privacy Officer at Saint Louis University, 1402 S. Grand Blvd., St. Louis, MO 63104 for further information about the complaint process.

**Acknowledgement of  
Receipt of Saint Louis University  
Notice of Privacy Practices**

Effective April 14, 2003  
Amended September 23, 2013

I hereby acknowledge that I received a copy of the Saint Louis University Notice of Privacy Practices.

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

\_\_\_\_\_  
**Signature of Patient or Patient's Representative**

\_\_\_\_\_  
**Print Patient or Representative Name**

\_\_\_\_\_  
Relationship of Representative to Patient

\_\_\_\_\_ Patient refused to sign acknowledgement.

\_\_\_\_\_  
Signature of Person Witnessing Refusal

MEDICAL RECORD COPY

**Saint Louis University and SLUCare  
Patient Consent To Treatment Form**

**This consent includes the following Saint Louis University and SLUCare Departments:**

Anesthesia	Otolaryngology	Surgery:
Community & Family Medicine	Pathology	Cardiothoracic
Dermatology	Pediatrics	General Surgery
Internal Medicine	Physical Therapy	Neurosurgery
Neurology	Psychiatry	Pediatric Surgery
OB/GYN	Radiation Oncology	Plastic Surgery
Ophthalmology	Radiology	Urology
Orthopaedic Surgery	Student Health	

**Patient's Name:** \_\_\_\_\_  
**(Please Print)**                      **First**                      **Middle**                      **Last**                      **Last 4 Digits of SSN**

**1. Medical Consent:**

I request and authorize my physician and other physicians who may attend to me, their associates and assistants, including those employed by Saint Louis University and its medical group known as SLUCare (Saint Louis University and SLUCare are hereinafter collectively referred to as SLU), its housestaff, employees and supervised students to provide and perform such medical care, tests, procedures, drugs and other special services and tests ordered by my physician. I am aware that the practice of medicine is not an exact science and I acknowledge that no representations, warranties, or guarantees as to results or cures have been made to, or relied upon, by me.

**2. Release of Information:**

I understand and acknowledge there are instances when information concerning my care, including copies of my medical records and/or billing information pertaining to my medical care, must be used by SLU or disclosed by SLU to certain individuals or representatives of agencies or organizations in connection with my care, payment for my care, and other activities related to my care. I also acknowledge that these and other permitted uses and disclosures are more fully described in the SLU Notice of Privacy Practices.

**3. Assignment of Insurance Benefits:**

In consideration of any and all medical services, care, drugs, supplies, equipment, and facilities furnished by SLU, and all attending physicians, I hereby irrevocably assign and transfer to said SLU and all attending physicians, all insurance benefits now due and payable to me under any insurance policy or policies thereof that might be applicable.

I hereby transfer payment of benefits for medical and/or surgical services rendered by physicians for whom SLU is authorized to charge and bill.

I understand that my obligations to pay all charges is not affected by the fact that I have insurance benefits and if my insurance company fails to pay all or any portion of these charges for any reason, I will be responsible for all sums due and owing SLU.

**4. Guarantee of Account:**

In consideration of any and all medical services rendered by SLU to the above-named patient, I agree to pay SLU the charges for all services ordered by the SLU physicians, patient and patient's family including any deductibles, coinsurance or amounts not paid by the patient's insurance plan, including Medicare and Medicaid. If the requirements for referral, second opinion, or pre-certification of my care, as outlined by my insurance carrier, have not been followed, I understand that I will be responsible for all charges incurred.

SLU and the patient or patient's representative hereby enter into the above agreement. The patient or patient's representative certifies that he/she has read and accepted the above, where applicable to the patient's condition and status, and further certifies that he/she is the patient, or is duly authorized on behalf of the patient to execute such an agreement.

\_\_\_\_\_  
**Patient's Signature/Person Authorized to Consent and Relationship**

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

\_\_\_\_\_  
**Guarantor of Account if Other Than Patient and Relationship to Patient**

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

**5. Medicare Insurance Benefits:**

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my own behalf. I understand I am responsible for the Part B deductible for each year, the remaining co-insurance and any other non-covered personal charges. I am also responsible for the Part A deductible for each occurrence of illness and any co-insurance amounts which may become due.

\_\_\_\_\_  
**Patient's Signature or Person Authorized to Consent and Relationship to Patient**

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

**I hereby certify that I have witnessed the signature(s) of the patient and/or individual signing on behalf of the patient.**

\_\_\_\_\_  
**Witness**

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