

**This NPP is currently used by all programs and projects of PHMC and Affiliates that provide healthcare services to persons.**

**Philadelphia Health Management Corporation  
Notice of Privacy Practices**

**THIS NOTICE DESCRIBES HOW YOUR PROTECTED HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO YOUR PROTECTED HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.**

We at Philadelphia Health Management Corporation are required by law to maintain the privacy of your protected health information and to provide you with this Notice describing our privacy practices. Protecting the privacy and confidentiality of information about our clients is very important to Philadelphia Health Management Corporation. Accordingly, we strive to comply with each of the following practices in everything we do.

**Protected Health Information (“PHI”) means individually identifiable health information, as defined by the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) that is created or received by PHMC and that relates to the past, present, or future physical or mental health condition of a individual; the provision of health care services to an individual; or the past, present, or future payment for the provision of health care services to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual.**

**USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION:**

We are permitted or required to use your health information for various purposes. The following categories describe different ways that we use and disclose PHI. However, uses or disclosures that we are permitted to make will generally fall within one of the following categories.

**FOR TREATMENT:**

With your consent, we may use and disclose your PHI in order to ensure that you receive proper and needed health care services. For example, we may disclose your health information to another health care provider involved in your care, or to whom you are being referred for additional health related services

**FOR PAYMENT:**

We may use and disclose your PHI so that we may obtain payment for the treatment and services we provided to you, from you, an insurance company, funding source or another third party payer. For example, we may need to give your insurance company or another payer information about your diagnosis, treatment, or services we provided to you in order for PHMC to receive payment and/or funding for the treatment and/or

services provided to you.

**FOR PHMC'S INTERNAL OPERATIONS:**

We may use and disclose your PHI for our internal operations. Operations is defined as those activities that are necessary to run our offices, maintain licensure, accreditation, obtain funding and to make sure that our clients receive quality care and/or services. For example, we may use your PHI to review our treatment of you and the services that we provided and/or coordinated for you to evaluate our performance in meeting your needs.

**BUSINESS ASSOCIATES:**

Certain aspects and components of the services PHMC offers are provided through contracts with outside persons and/or organizations. Examples of these outside persons and /or organizations include other duly appointed providers of services. For example, it may be necessary for us to provide certain aspects of your PHI to one or more of these outside persons or organizations in order to coordinate appropriate treatment and/ or services for you.

**AS REQUIRED BY LAW:**

We may use or disclose your PHI for any purpose required by law. For example, PHMC may be required by federal, state or local law to use or disclose your PHI to respond to a court order or disclose PHI to the proper authorities for law enforcement purposes.

**GOVERNMENT OVERSIGHT AGENCIES:**

We may use or disclose your PHI if authorized by law to a government oversight agency conducting audits, investigations, or civil or criminal proceedings. For example, the Department of Public Welfare that conducts audits of medical assistance payments for services provided.

**FOR PREVENTION OF VIOLENCE:**

We may disclose your PHI to the proper authorities if we suspect child abuse or neglect; we may also disclose your PHI if we believe you to be a victim of abuse, neglect or domestic violence.

**FOR PUBLIC HEALTH ACTIVITIES:**

We may use or disclose certain PHI for public health activities, such as reporting of disease, injury, birth and death, and for public health investigations. We may also disclose your PHI to coroners, medical examiners, and/or funeral directors consistent with law.

**TO AVERT A SERIOUS THREAT TO PUBLIC HEALTH OR SAFETY:**

We may use and disclose PHI about you when necessary to prevent a serious threat to your health and safety or that of the public or another person. Any disclosure however,

would only be made to an agency or person able to help prevent the threatened harm.

**MILITARY PURPOSES:**

We may use or disclose your PHI if you are a member of the military as required by armed forces services, and we may also disclose your PHI for other specialized government functions such as national security or intelligence activities.

**WORKERS' COMPENSATION:**

We may disclose your PHI, If you are injured at work, to workers' compensation agencies or similar programs that provide benefits for work related injuries or illness as required or permitted by law.

**SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES:**

We will, if required by law release your PHI to the Secretary of the Department of Health and Human Services for enforcement of the Health Insurance Portability and Accountability Act.

## PHILADELPHIA HEALTH MANAGEMENT CORPORATION

### YOUR RIGHTS IN CONNECTION WITH YOUR PROTECTED HEALTH INFORMATION

You have the following rights in connection with the protected health information we maintain about you:

#### **RIGHT TO INSPECT AND COPY:**

You have the right to inspect and copy your PHI that is in our possession. Certain requests for access to your PHI must be in writing, must state that you want access to your PHI and must be signed by you or your representative. For example, requests for copies of treatment/service records.

#### **RIGHT TO REQUEST AMENDMENT:**

You have the right to request that PHI that we maintain about you be amended or corrected, if you feel that your PHI is incorrect or incomplete. To request an amendment, your request must be made in writing and submitted to our office. You must state in your request why you believe that the PHI is incorrect or incomplete. We are not obligated to make all requested amendments, but will give each request careful consideration. If we deny your request, you have a right to give us a short statement to be placed with your PHI or to have your request for amendment attached to your PHI..

#### **RIGHT TO AN ACCOUNTING OF DISCLOSURES:**

You have the right to request, and we must provide you with a list of certain disclosures of your PHI. We are not required to include on those list disclosures to carry out your treatment, payment for treatment and/or services provided you and/or our internal operations. To request this list or accounting of disclosures, you must submit your request in writing to our office.

#### **RIGHT TO REQUEST RESTRICTIONS:**

You have a right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment or internal operations, disclosures made to persons involved in your care, and disclosures for disaster relief purposes. For example, you may request that we not disclose your PHI to your spouse. Your request must describe in detail the restriction you are requesting. HIPAA does not require us to agree to your request, but we will accommodate reasonable requests when appropriate. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction. Requests for a restriction (or termination of an existing restriction) may be made, by contacting PHMC

at the telephone number or address below.

**RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS:**

You have the right to request that we communicate with you about PHI in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. Your request must specify how or where you wish to be contacted. To request confidential communications, you must make your request in writing to our office. We will not ask you the reason for your request, and we will accommodate all reasonable requests.

**RIGHT TO A PAPER COPY OF THIS NOTICE:**

You may ask us to give you a copy of this notice at any time by asking for it in person or writing. Please note that we retain the right to modify this notice.

**COMPLAINTS:**

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of U.S. Department of Health and Human Services. To file a complaint with us, contact our office in writing. You will not be penalized for filing a complaint.

If you have any questions about this notice, please contact our Privacy Officer at Philadelphia Health Management Corporation, 260 South Broad Street, Philadelphia, PA 19102

**PHILADELPHIA HEALTH MANAGEMENT CORPORATION**

**PATIENT ACKNOWLEDGEMENT AND CONSENT**

In order to provide care to you, it will be necessary for us to use and/or disclose your protected health information for purposes of treatment, payment, and health care operations. Maintaining the confidentiality of that information is important to us. Our Notice of Privacy Practices describes in more detail the uses and disclosures of your protected health information that are necessary and our obligations to protect that information. You have the right to review the Notice before you sign this Consent. By signing this Consent, you are agreeing that \_\_\_\_\_, a program of the Philadelphia Health Management Corporation, the professional staff and other individuals involved in your care, may use and disclose your protected health information in connection with your treatment, payment for your care and PHMC's health care and data base.

We may change our privacy practices and our Notice of Privacy Practices in the future. If we change our privacy practices, you may obtain a copy of the revised Notice by visiting our website at [www.phmc.org](http://www.phmc.org), by requesting a copy in person from the program staff or by sending a written request to \_\_\_\_\_, Privacy Coordinator, \_\_\_\_\_

You have the right to request that PHMC restricts how your protected health information is used or disclosed for treatment, payment, or health care operations. PHMC is not required to agree to the restrictions you request, but if we do agree to a requested restriction, we are obliged by that restriction.

You have the right to revoke this consent at any time, in writing, except to the extent that PHMC has previously used or disclosed your protected health information in reliance on this Consent.

I hereby acknowledge that I have been offered/received a copy of the Philadelphia Health Management Corporation's notice of Privacy Practices. I consent to the uses and disclosures of my personal health information as outlined in the Notice of Privacy Practices for treatment, payment, and operations.

\_\_\_\_\_  
**Print name of Patient**

\_\_\_\_\_  
**Patient/ Representative Signature**

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

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

Patient/personal representative refuses to sign. \_\_\_\_\_  
**Staff signature** **Date**