

PRIVACY POLICY

PURPOSE:

To implement compliance with the privacy regulations (45.C.F.R.164.500 et seq.) issued by the Department of Health and Human Services (“HHS”) under the Health Insurance, Portability and Accountability Act (HIPAA) the **Memorial Health Center** (facility) has appointed a privacy officer. The privacy officer’s duties are attached hereto as Exhibit A.

The general policy of the facility is to provide to a patient/resident, as permitted by law, his or her protected health information and to protect the confidentiality of such health information as required by law.

IMPLEMENTATION:

PERSONNEL DESIGNATION:

1. M.H.C. Privacy Officer is designated as the privacy official responsible for the development and implementation of the policies and procedures for the facility.
2. M.H.C. has designated a contact person responsible for receiving requests and complaints related to access, privacy, amendment, and accountings of protected health information and any other request or complaint relating to Protected Health Information issues and such person will be able to provide further information about matters covered in the facility’s privacy notice.

TRAINING:

The facility will use their best efforts to train all members of its workforce (i.e. employees, volunteers, clergy, PRN’s, etc) on the policies and procedures as to Protected Health Information. All staff shall receive such training no later than April 14,2003. Thereafter, new members of the workforce will receive such training in a reasonable time after they join the workforce. Periodic training will occur for all staff and when there has been a material change in the policies or procedures.

All training will be documented. Such documentation will be maintained in their personnel file.

SAFEGUARDS:

The facility will put in place appropriate administrative, technical, and physical safeguards to protect the privacy of Protected Health Information. The safeguards include, but are not limited to, the following:

Administrative Safeguards:

1. Privacy Officer designated
2. Established a HIPAA Compliance Team
3. Provided initial training to workforce
4. Provides ongoing training and new workforce training at orientation

Technical Safeguards

1. Computer system updated to be HIPAA compliant
2. Facility has contracted with a technical Consultant for on going compliance efforts
3. Facility has implemented a specific policy on user passwords
4. Facility has implemented a specific policy on computer access by outside sources – need to know basis only.

Physical Safeguards

1. Facility is using its' best efforts to secure all IHHI by placing medical records in an area that is accessible only by authorized staff.
2. Facility is using it's best efforts to maintain the privacy of IHHI by staff keeping all charts closed when not in use.
3. Facility has updated its lock down policy and procedure to further protect IHHI.

Such safeguards are intended to reasonably safeguard Protected Health Information from intentional or unintentional use or disclosure.

COMPLAINTS TO THE FACILITY:

The facility has established a process through which a patient/resident may make complaints to the facility regarding its policies and procedures. Notice of this complaint process and information on initiating the complaint process is provided with notice given to all new patients/residents.

Furthermore, the facility will post a sign that indicates that patients/residents may request a complaint form if the patient/resident has a complaint or issue concerning any aspect of the facility's privacy policies.

When any patient/resident requests a complaint form, the member of the workforce to whom the request is made shall refer the patient/resident to the designated staff member. The designated staff member shall provide the form to the patient/resident and inform the patient/resident to complete the form and return it.

Upon receipt of a written complaint, the designated staff member shall investigate the complaint and form an ad hoc committee consisting of appropriate members of the facility's staff. After investigating the complaint, and considering the merits of the complaint, the ad hoc committee shall make a recommendation to the governing body of the facility as to the appropriate action on the complaint.

Upon receipt of the recommendation from the ad hoc committee, the governing body shall make a determination as to the merits of the complaint and direct such further action as is necessary. The governing body shall notify the designated staff member to advise the patient/resident of the governing body's resolution of the issue.

The privacy officer shall maintain copies of all complaints and of resolution of the complaints.

SANCTIONS:

The facility will apply appropriate sanctions against members of its staff who fail to comply with the facility's policies and procedures. Any sanctions applied shall be documented.

MITIGATION:

To the extent of a violation of the privacy regulations or the facility's privacy policies occurs, the facility will mitigate to the extent practicable any harmful effect that is known to the facility because of the violation.

REFRAIN FROM INTIMIDATING OR RETALIATORY ACTS:

The facility will not intimidate, threaten, coerce, discriminate against, or take any other retaliatory action against an individual for exercising legal rights granted patients by law.

WAIVER OF RIGHTS:

The facility will not require individuals to waive any rights under HIPAA or its privacy policies as a condition or provision of treatment.

RETENTION OF DOCUMENTS:

To the extent such documents are not required to be kept longer by other applicable federal or state law, documents relating to the implementation and compliance with HIPAA and these privacy policies and procedures shall be maintained for a minimum of six years.

CONSENT:

To the extent required, the facility will obtain a consent prior to, or at the time of, creating a relationship with a patient/resident allowing such entity to use and disclose Protected Health Information for treatment, payment and health care operations as required by law.

AUTHORIZATIONS:

To the extent required by law, the facility will obtain an authorization prior to disclosing any Protected Health Information.

ACCESS:

The facility will establish a procedure to allow patients/residents to obtain access to their Protected Health Information within a reasonable time.

ACCOUNTING:

The facility shall maintain an accounting, as required by law, reflecting any uses or disclosures of Protected Health Information.

AMENDMENTS:

The facility shall establish a procedure for allowing an individual to request that its records be maintained in a certain confidential manner and that communications be transmitted to him/her a certain way.

CONFIDENTIALITY & COMMUNICATION REQUESTS:

The facility shall establish a procedure for allowing an individual to request that its records be maintained in a certain confidential manner and that communications be transmitted to him/her a certain way.

NOTICE:

The facility shall distribute a Notice of Policies to all new patient/residents and make revised notices available to all patient/residents.