



809 Elm Street Suite 1200  
Alexandria, MN 56308  
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320.763.4127 fax  
[horizonpublichealth.org](http://horizonpublichealth.org)

## HIPAA NOTICE OF PRIVACY PRACTICES

**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.**

### PURPOSE

Horizon Public Health is committed to protecting the personal health information of our clients. The Health Insurance Portability and Accountability Act (HIPAA) provides rules to follow when we use or disclose your Protected Health Information (PHI). PHI is any information collected about you regarding your health and includes demographics such as your sex and age. This notice is intended to help you understand what we can and cannot do with your PHI, what your rights are, and who to contact for questions or complaints.

### USE AND DISCLOSURE OF HEALTH INFORMATION

HIPAA allows us to use and disclose your health information for treatment, obtaining payment for your care and conducting health care operations without asking your permission. Following are examples of how we may use your health information.

**To Provide Treatment:** We may use your health information to coordinate care within the agency and with others involved in your care, such as your doctor. For example, your doctor will need information about your symptoms to prescribe appropriate medications. We may also disclose your health information to others involved in your care including family members, pharmacists, medical equipment suppliers, and other health care professionals.

**To Obtain Payment:** We may use your health information to obtain payment. For example, we may be required by your health insurance to provide information regarding your health care status so the insurer will reimburse you or us. We may need to obtain approval from your insurer before providing service to you and may need to disclose your health information to obtain approval.

**To Conduct Health Care Operations:** We may use and disclose your health information for non-treatment and non-payment activities that let us run our business or provide services. This includes quality improvement and assessment activities, staff training and evaluation, conducting or arranging for medical review, medical and administrative appeals, legal services, law enforcement activities, audit services, fraud and abuse detection programs, working with Business Associates who perform functions on our behalf and other general business related activities. For example, we may use your health information to evaluate staff performance, combine your health information with other client information in evaluating how to more effectively serve all of our clients, disclose your health information to agency staff and to contracted personnel for training purposes, and for general administrative duties such as cost management, customer service, and resolution of complaints you may register.

**Other Uses and Disclosures:** We may contact you to give appointment reminders, tell you about treatment options, or other health benefits and services that may be of interest to you. For example, we may send you health care ideas for things like women's/men's health, diabetes, asthma, etc. We may disclose enrollment/disenrollment information and "summary health information" (as defined under the HIPAA medical privacy regulations) for the purpose of obtaining premium bids or modifying or terminating health insurance coverage).

**Douglas County**  
809 Elm Street Suite 1200  
Alexandria, MN 56308  
320.763.4127 fax

**Grant County**  
15 Central Ave N, PO Box 191  
Elbow Lake, MN 56531  
888.209.2887 fax

**Pope County**  
211 E Minnesota Ave Suite 100  
Glenwood, MN 56334  
320.634.0159 fax

**Stevens County**  
10 E Hwy 28  
Morris, MN 56267  
320.589.7433 fax

**Traverse County**  
202 8th Street N, PO Box 23  
Wheaton, MN 56296  
320.563.0104 fax

**Uses and Disclosures Authorized by Law:** Under certain circumstances we may be required or permitted to disclose your Health Information without obtaining consent or authorization from you:

- *When legally required to do so by federal, state, or local law:* Includes response to court or administrative orders, or to report information to law enforcement regarding suspected criminal activity.
- *When there are risks to public health:* We may disclose your health information in order to prevent or control disease, report disease, injury, and vital events such as birth or death. We may report adverse events and product defects to enable product recalls, repairs and replacements.
- *To report abuse, neglect or domestic violence*
- *To conduct health oversight activities:* Your health information may be disclosed to authorities that monitor our compliance with these regulations and other state or federal regulations for program we provide.
- *To coroners, medical examiners, and funeral directors:* For purposes of determining your cause of death, for other duties, and to carry out duties with respect to your funeral arrangements, as authorized by law.
- *For organ, eye or tissue donation:* If you are a donor, we may disclose your health information to organ procurement organizations to facilitate the donation.
- *In the event of a serious threat to health or safety:* Consistent with applicable law and ethical standards of conduct, we may disclose your health information if we believe that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or the health and safety of the public.
- *To the military, certain federal officials for national security activities, and to correctional institutions*
- *For workers compensation*
- *To a school as proof of immunization*

### **Uses and Disclosures that Require Authorization**

We are required to get a specific written authorization from you to use or disclose your Health Information for any purpose not described in this notice. If you or your representative authorize us to disclose information for other reasons, you may revoke that authorization in writing at any time. To do so, write or call Horizon Public Health and request a *Request to Revoke the Authorization to Use or Disclose Protected Health Information (PHI) Form*. Your permission will end when we receive the signed form or when we have acted on your request.

### **Your Rights Regarding Your Health Information**

You have the following rights with regard to your protected health information:

**Right to restrict our use or disclosure:** You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on our disclosure of your health information to someone involved in your care or the payment of your care. This includes restricting information family members are given. While we will consider your request, we are not legally required to agree to the additional restrictions. If we agree, we will not violate the agreement unless we need to for emergency treatment purposes. If we agree to a restriction and later determine we can no longer honor your request we will notify you of the termination of the restriction agreement. The termination would only apply to health information received after we provide you notice of the termination. Restriction requests must be submitted in writing on a form we provide.

**Right to request Alternative Communications:** You have the right to request that we communicate with you in a certain way. We will not require you provide any reasons for your request and will attempt to honor your request. For example, you may request that we contact you at an address other than your home address. We must agree to your request if you clearly state that the disclosure of specific Health Information could endanger you. Alternative communication requests must be submitted in writing on a form we provide.

**Right to view and copy your health information:** You have the right to view and/or copy your health information, including billing records. You have a right to choose what portions of your health information you want copied and to have prior notice of copying costs (a reasonable fee may be charged). There are limited situations in which we may deny your request for access. We will give you a written response regarding if your request is granted or denied and how to appeal.

**Right to amend health information:** You, or your representative, have the right to amend your health information if you believe it is incomplete or inaccurate. Your request must be submitted in writing on a form we provide and must include an explanation of why you feel the information should be amended. If we approve your request, we will make reasonable efforts to inform others, including people you name, about the amendment to your health information. We may deny your request for various reasons, for example, if we determine the information is complete or accurate or if we did not create the information. We will inform you in writing if we accept or deny your request and what further actions you may take.

**Right to an accounting:** You have the right to receive a listing from us of all instances in which we disclosed your health information for purposes other than treatment, payment, health care operations, or as authorized by you. The list will include only disclosures made on or after April 14, 2003 and will only go back six years. We will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests will be subject to a reasonable fee to cover costs involved to respond to your request.

**Right to a paper copy of this notice:** You or your representative have a right to a paper copy of this notice at any time even if you have previously received it. We reserve the right to change this notice, outlining our privacy practices, at any time. We will not make changes in the implementation of our privacy practices without first sending you a revised notice.

**Right to be notified if there was a breach** of your personal health information, if the unauthorized acquisition, access, use, or disclosure of PHI poses a "significant risk of financial, reputational, or other "harm" to you.

Horizon Public Health reserves the right to change the terms of this notice.

**CONTACT INFORMATION FOR QUESTIONS AND SUBMISSIONS OF FORMS**

Please send questions, requests, or forms, to the following address:

Horizon Public Health  
Privacy Officer  
809 Elm Street Suite 1200  
Alexandria, MN 56308  
Phone: 800-450-4177 or 320-763-6018

**Complaints:** In addition to notifying the privacy officer above, you may also submit a written complaint to the Secretary of the U.S. Department of Health and Human Services if you feel your privacy rights have been violated. We will not retaliate in any way if you choose to file a complaint. The address is:

Region V Office for Civil Rights  
U.S. Department of Health & Human Services  
233 N. Michigan Ave, Ste. 240  
Chicago, IL 60601  
Hotline: 1-800-368-1019 (toll free)

**EFFECTIVE DATE OF THIS NOTICE**

This Notice is effective as of January 1, 2015

No Guarantee of Employment: Nothing contained in this Notice shall be construed as a contract of employment between Horizon Public Health and any employee, nor as a right of any employee to be continued in the employment of Horizon Public Health, or as a limitation of the right of Horizon Public Health to discharge any of its employees, with or without cause.

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