



## **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.**

### **I. Our Duty to Safeguard Your Protected Health Information**

We are committed to preserving the privacy and confidentiality of your health information. We are required by certain state and federal regulations to implement policies and procedures to safeguard your health information. Copies of our privacy policies and procedures are maintained in our business office. We are required by state and federal regulations to abide by the privacy practices described in this notice, including any future revisions that we may make to the notice as may become necessary or as authorized by law.

Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care treatment or services you receive is considered *protected health information* (PHI). Accordingly, we are required to provide you with this Privacy Notice that contains information regarding our privacy practices to explain how, when and why we may use or disclose your PHI and your rights and our obligations regarding any such uses or disclosures. Except in specified circumstances, we must use or disclose only the minimum amount of PHI necessary to accomplish the intended purpose of the use or disclosure of such information.

We reserve the right to change this notice at any time and to make the revised or changed notice effective for PHI that we already have about you as well as any information we receive in the future about you. Should we revise/change this Privacy Notice, we will promptly post the revision on our company's website at [www.libertyhomecare.com](http://www.libertyhomecare.com). You also may request and obtain a copy of any new/revised Privacy Notice from the contact person identified on the last page of this notice.

Should you have questions concerning our Privacy Notice, our contact information is listed on the last page of this document.

## **II. How We May Use and Disclose Your Protected Health Information**

We use and disclose protected health information for a variety of reasons. We have a limited right to use and/or disclose your protected health information for purposes of treatment, payment, or for health care operations. For other uses and disclosures, you must give us your written authorization to release your protected health information unless the law permits or requires us to make the use or disclosure without your authorization.

Should it become necessary to release or give access to your protected health information to an outside party performing services on our behalf (*e.g.*, maintaining our computers), we will require the party to have a signed agreement with us that the party will extend the same degree of privacy protection to your information as we do.

The privacy law permits us to make some uses or disclosures of your protected health information without your consent or authorization. The following describes each of the different ways that we may use or disclose your protected health information. Where appropriate, we have included examples of the different types of uses or disclosures. These include:

### **1. Use and Disclosures Related to Treatment**

We may disclose your protected health information to those who are involved in providing medical and nursing care services and treatments to you. For example, we may release protected health information about you to nurses, nursing assistants, medication aides/technicians, medical and nursing students, therapists, other pharmacists, medical records personnel, other consultants, physicians, etc. We may also disclose your protected health information to outside entities performing other services relating to your treatment; such as long term care facilities, hospitals, diagnostic laboratories, home health/hospice agencies, family members, etc.

### **2. Use and Disclosures Related to Payment**

We may use or disclose your protected health information to bill and collect payment for items or services we provided to you. For example, we may contact your insurance company, health plan, or another third party to obtain payment for services we provided to you.

### **3. Use and Disclosures Related to Health Care Operations**

We may use or disclose your protected health information for the performance of certain functions in monitoring and improving the quality of care and services that you and others receive. For example, we may use your protected health information to evaluate the effectiveness of the care and services you are receiving. We may also disclose your protected health information for auditing, care planning, quality improvement, and learning purposes.

### **4. Use and Disclosures Related to Treatment Alternatives, Health-Related Benefits and Services**

We may use or disclose your protected health information for purposes of contacting you to inform you of treatment alternatives or health-related benefits and services that may be of interest to you, such as a newly released medication or treatment that has a direct relationship to a treatment or medical condition.

### **III. Uses and Disclosures Requiring Your Written Authorization**

For uses and disclosures of your protected health information beyond the above excepted purposes, we are required to have your written authorization, except as otherwise required or permitted by law. You have the right to revoke an authorization at any time to stop future uses or disclosures of your information except to the extent that we have already undertaken an action in reliance upon your authorization. Your revocation request must be provided to us in writing. Our contact information for purposes of revoking your authorization is listed on the last page of this document. You may use our *Authorization for Use or Disclosure of Protected Health Information* form and/or our *Revocation of an Authorization* form to submit your request to us. Copies of these forms are available upon request.

Examples of uses or disclosures that would require your written authorization include, but are not limited to, the following:

1. A request to provide your protected health information to an attorney for use in a civil litigation claim.
2. A request to provide certain information to an insurance or pharmaceutical company for the purposes of providing you with information relative to insurance benefits or new medications that may be of interest to you.
3. A request to provide PHI to another individual or facility, where no exception from the written authorization requirement applies.

### **IV. Uses or Disclosures of Information Based Upon Your Verbal Agreement**

In the following situations, we may disclose a limited amount of your protected health information if we provide you with an advance oral or written notice and you do not object to such release or such release is not otherwise prohibited by law. However, if there is an emergency situation and you are unable to object (*e.g.*, because you were not present or you were incapacitated), disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interest. When a disclosure is made based on these or emergency situations, we will only disclose protected health information relevant to the person's involvement in your care. For example, if you are having an adverse reaction to a medication, and are not able to communicate with us effectively, we may inform a family member involved in your care of your drug regimen and possible side effects. You will be informed and given an opportunity to object to further disclosures of such information as soon as you are able to do so.

We may disclose your protected health information to your family members and friends who are involved in your care or who help pay for your care. We may also disclose your protected health information to a disaster relief organization for the purposes of notifying your family and/or friends about your general condition, location, and/or status (*i.e.*, whether you are alive or dead). You may object to the release of this information. You may use our *Request to Restrict the Use or Disclosure of Protected Health Information* form to notify us of your objection or your objection may be made orally. Our contact information is listed on the last page of this document. (See also Section VI, paragraph 1.)

## **V. Uses and Disclosures of Information That Do Not Require Your Consent or Authorization**

State and federal laws and regulations in some instances either require or permit us to use or disclose your protected health information without your consent or authorization. The uses or disclosures that we may make without your consent or authorization include the following:

### **1. When Required by Law:**

We may disclose your protected health information when required by federal, state or local law.

### **2. Abuse, Neglect, or Domestic Violence:**

As required or permitted by law, we may disclose protected health information about you to a state or federal agency to report suspected abuse, neglect, or domestic violence. If such a report is optional, we will use our professional judgment in deciding whether or not to make such a report. If feasible, we will inform you promptly that we have made such a disclosure.

### **3. Communicable Diseases:**

To the extent authorized by law, we may disclose information to a person who may have been exposed to a communicable disease or who is otherwise at risk of spreading a disease or condition.

### **4. Disaster Relief:**

We may disclose protected health information about you to government entities or private organizations (such as the Red Cross) to assist in disaster relief efforts.

### **5. Food and Drug Administration (FDA):**

We may disclose protected health information about you to the FDA, or to an entity regulated by the FDA, in order, for example, to report an adverse event or a defect related to a drug or medical device.

### **6. For Public Health Activities:**

As required or permitted by law, we may disclose protected health information about you to a public health authority, for example, to report disease, injury, or vital events such as death.

### **7. For Health Oversight Activities:**

We may disclose your protected health information to a health oversight agency such as a protection and advocacy agency, or to other agencies responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents or to ensure that we are in compliance with applicable state and federal laws and regulations, including civil rights laws.

### **8. To Coroners, Medical Examiners, Funeral Directors, Organ Procurement Organizations or Tissue Banks:**

We may disclose your protected health information to a coroner or medical examiner for the purpose of identifying a deceased individual or to determine the cause of death. We may also disclose your protected health information to a funeral director for the purposes of carrying out your wishes and/or for the funeral director to perform his/her necessary duties. If you are an organ donor, we may disclose your protected health information to the organization that will handle your organ, eye or tissue donation for the purposes of facilitating your organ or tissue donation or transplantation.

**9. For Research Purposes:**

We may disclose your protected health information for research purposes without your authorization only when a privacy board has approved the research project. We may use or disclose your protected health information to individuals preparing to conduct an approved research project in order to assist such individuals in identifying persons to be included in the research project. Researchers identifying persons to be included in the research project will not be permitted to remove protected health information from our control. If it becomes necessary to use or disclose information about you that could be used to identify you by name, we will obtain your written authorization before permitting the researcher to use your information. Researchers will be required to sign a *Confidentiality and Non-Disclosure Agreement* form before being permitted access to protected health information for research purposes. A sample copy of this agreement may be obtained from our business office.

**10. To Avert a Serious Threat to Health or Safety:**

We may disclose your protected health information to avoid a serious threat to your health or safety or to the health or safety of others. When such disclosure is necessary, information will only be released to those law enforcement agencies or individuals who have the ability or authority to prevent or lessen the threat of harm.

**11. For Judicial or Administrative Proceedings:**

We may disclose protected health information about you in the course of a judicial or administrative proceeding, in accordance with our legal obligations.

**12. To Law Enforcement:**

We may disclose protected health information about you to a law enforcement official for certain law enforcement purposes. For example, we may report certain types of injuries as required by law, assist law enforcement to locate someone such as a fugitive or material witness, or make a report concerning a crime or suspected criminal conduct.

**13. Minors:**

If you are an unemancipated minor as defined under state law, there may be circumstances in which we disclose protected health information about you to a parent, guardian, or other person acting *in loco parentis*, in accordance with our legal and ethical responsibilities.

**14. Parents:**

If you are a parent of an unemancipated minor, and are acting as the minor's personal representative, we may disclose protected health information about your child to you under certain circumstances. For example, if we are legally required to obtain your consent as your child's personal representative in order for your child to receive care or services from us, we may disclose protected health information about your child to you. In some circumstances, we may not disclose protected health information about an unemancipated minor to you. For example, if your child is legally authorized to obtain services (without separate consent from you), and does not request that you be treated as his or her personal representative, we may not be required to disclose protected health information about your child to you without your child's written authorization.

**15. To Personal Representatives:**

If you are an adult or emancipated minor, we may disclose protected health information about you to a personal representative authorized to act on your behalf in making decisions about your health care.

**16. For Specific Government Functions:**

We may disclose protected health information about you for certain specialized government functions, as authorized by law. Among these functions are the following: military command; determination of veterans benefits; national security and intelligence activities; protection of the President and other officials; and the health, safety, and security of correctional institutions.

**17. For Workers' Compensation:**

We may disclose protected health information about you for purposes related to workers' compensation, as required and authorized by law.

**VI. Your Rights Regarding Your Protected Health Information**

You have the following rights concerning the use or disclosure of your protected health information that we create or that we may maintain about you:

**1. To Request Restrictions on Uses and Disclosures of Your Protected Health Information:**

You have the right to request that we limit how we use or disclose your protected health information for treatment, payment or health care operations. You also have the right to request a limit on the protected health information we disclose about you to someone who is involved in your care or the payment for your care or services. For example, you could request that we not disclose to family members or friends information about a medical treatment you received.

Should you wish a restriction placed on the use and disclosure of your protected health information, you must submit such request in writing. Such request should be submitted using our *Request to Restrict the Use and Disclosure of Protected Health Information* form. Our contact information for purposes of making such a request is listed on the last page of this document.

***We are not required to agree to your restriction request.*** You will be informed if we decline your request. If we accept your request, we will comply with your request not to release such information unless the information is needed to provide emergency care or treatment to you.

**2. The Right to Inspect and Copy Your Health and Billing Records:**

You have the right to inspect and copy your protected health information, such as your prescription and billing records. In order to inspect and/or copy your protected health information, you must submit a written request to us. If you request a copy of your prescription or billing information or other records, we may charge you a reasonable fee for the paper, labor, mailing, and/or retrieval costs involved in filing your requests. We will provide you with information concerning the cost of copying your protected health information prior to performing such service. Such requests should be submitted on our *Request for Inspection/Copy of Protected Health Information* form. Our contact information for such requests is listed on the last page of this document.

We will respond within thirty (30) days of receipt of such requests. Should we deny your request to inspect and/or copy your protected health information, we will provide you with written notice

of our reasons of the denial and your rights for requesting a review of the denial, if any. In the event of a review, we will select a licensed health care professional not involved in the original denial process to review your request and our reasons for denial. We will abide by the reviewer's decision concerning your inspection/copy requests. Your denial review request should be submitted on our *Denial of Inspection/Copy of Protected Health Information* form. Copies of these forms are available from the contact person listed on the last page of this document.

### **3. The Right to Amend or Correct Your Protected health information:**

You have the right to request that your protected health information be amended or corrected if you have reason to believe that certain information is incomplete or incorrect. You have the right to make such requests of us for as long as we maintain/retain your protected health information. Your requests must be submitted to us in writing. We will respond within sixty (60) days of receiving the written request, unless an extension is necessary, in which case you will be notified, and receive a response to your request within ninety (90) days. If we approve your request, we will make such amendments/corrections and notify those with a need to know of such amendments/corrections.

We may deny your request if:

- a. Your request is not submitted in writing;
- b. Your written request does not contain a reason to support your request;
- c. The information was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- d. It is not a part of the protected health information kept by us;
- e. It is not part of the information which you would be permitted to inspect and copy; and/or
- f. The information is already accurate and complete.

If your request is denied, we will provide you with a written notification of the reason(s) of such denial and your rights to have the request, the denial, and any written response (of reasonable length) you may have relative to the information and denial process appended to your protected health information.

Your amendment/correction request should be submitted on our *Request for Amendment/Correction of Protected Health Information* form. Copies of these forms are available from our business office. Our contact information for the purpose of making such a request is listed on the last page of this document.

### **4. The Right to Request Confidential Communications:**

You have the right to request that we communicate with you about your health matters in a certain way or at a certain location. For example, you may request that we not send any protected health information to you at a health care facility, but instead send communication for you to a residential address or Post Office Box. We will agree to your request as long as it is reasonable for us to do so.

You may submit your requests on our *Request for Restriction of Confidential Communications* form. Copies of these forms are available from the contact person listed on the last page of this document. Our contact information is listed on the last page of this document.

**5. The Right to Request an Accounting of Disclosures of Protected Health Information:**

You have the right to request that we provide you with a listing of certain disclosures of your protected health information that we have made over a specified period of time. This accounting will not include any information we have made for the purposes of treatment, payment, or health care operations or information released to you, your family or friends for notification purposes, disclosures made for national security purposes or to certain law enforcement officials, incidental disclosures, disclosures made as part of a limited data set (for use in research, public health, etc.), or any disclosures made pursuant to your authorization. Your request must be submitted to us in writing and must indicate the time period for which you wish the information (e.g., May 1, 2003 through August 31, 2003). Your request may not include releases for more than six (6) years **prior** to the date of your request and may not include releases **prior** to April 14, 2003. Your request must indicate in what form (e.g., printed copy or email) you wish to receive this information. We will respond to your request with sixty (60) days of the receipt of your written request. Should additional time be needed to reply, you will be so notified. However, in no case will such extension exceed thirty (30) days. The first accounting you request during a twelve (12) month period will be free. There may be a reasonable fee for additional requests during the twelve (12) month period. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. You may submit your requests on our *Request for an Accounting of Disclosures of Protected Health Information* form available from our business office. Our contact information is listed on the last page of this document.

**6. The Right to Receive a Paper Copy of This Notice:**

You have the right to receive a paper copy of this notice even though you may have agreed to receive an electronic copy of this notice. You may request a paper copy of this notice at anytime or you may obtain a copy of this information from our website (as applicable). Our contact information is listed on the last page of this document.

**VI. How to File a Complaint About Our Privacy Practices**

If you have reason to believe that we have violated your privacy rights or our privacy policies and procedures, or if you disagree with a decision we made concerning access to your protected health information, you have the right to file a complaint with us or the Secretary of the U.S. Department of Health and Human Services. You will not be retaliated against for filing a complaint.

**Our contact information:**

**HIPPA Compliance Officer  
P.O. Box 339, Whiteville, N.C. 28472  
910-642-3065 (Phone)  
910-642-3765 (Fax)**



## **McNeill's Pharmacy NOTICE OF PRIVACY PRACTICES**

### **Record of Acknowledgment / Documentation of Good Faith Effort to Obtain Acknowledgment**

Name[Resident/Patient]: \_\_\_\_\_ Date: \_\_\_\_\_

#### **Effective Date of This Privacy Notice**

The effective date of this Privacy Notice is April 1st of 2003.

#### **Contact Information for Questions, Complaints or Requests Regarding Your Health Information**

Should you have any questions concerning our privacy practices, obtaining a copy of our privacy notice, requesting restrictions on the release of your information, revoking an authorization, amending or correcting your protected health information, obtaining an accounting of our disclosures of your protected health information, requesting inspection or copying of your medical information, requesting that we communicate information about your health matters in a certain way, filing complaints, or any other concerns you may have relative to our privacy practices, please contact:

**HIPAA Compliance Officer**  
**P.O. Box 339, Whiteville, N.C. 28472**  
**910-642-3065 (Phone)**  
**910-642-3765 (Fax)**

If you wish, you may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. You may mail your complaint to U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, DC 20201; or you may call (202) 619-0257 or 1-877-696-6775 (toll free); or you may log on to the internet address, <http://www.hhs.gov/ocr>.

#### **Acknowledgment / Good Faith Effort to Obtain Acknowledgment** *(check one of the following)*

[ ] I certify that I received a copy of the above-named entity's Privacy Notice and that I have had an opportunity to review this document and ask questions to assist me in understanding my rights relative to the protection of my health information. I am satisfied with the explanations provided to me and I am confident that the above-named entity is committed to protecting my health information.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

☐ I certify that I am the authorized representative of above-identified patient, and that I have received the Privacy Notice on behalf of this individual and that the above-named entity provided me with an opportunity to review this document and ask questions to assist me in understanding the patient's privacy rights. I am satisfied with the explanations provided to me and I am confident that the above-named entity is committed to protecting health information.

Date: \_\_\_\_\_

Signature of Representative: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Relationship to Individual: \_\_\_\_\_

☐ I, \_\_\_\_\_, certify that I made a good faith effort to obtain the acknowledgment of the above identified [resident/patient] or his/her personal representative that he/she had received a copy of the Privacy Notice of the above-identified entity, but was unable to obtain such acknowledgment for the following reason(s):

☐ [Resident/Patient] or personal representative refused to sign.

☐ [Resident/patient] or personal representative was unavailable to sign.

☐ Other: \_\_\_\_\_

Date: \_\_\_\_\_

Signature/Title: \_\_\_\_\_

**A copy of this document must be provided to the person to whom the Privacy Notice was provided and a copy must be filed in the patient's record.**