Form 3

SUMMIT COUNTY PUBLIC HEALTH
REGISTRATION FORM

Summit County Public Health

1867 West Market Street ♦ Akron, Ohio 44313-6901

Phone: (330) 923-4891 ♦ Toll-free: 1 (877) 687-0002 ♦ Fax: (330) 923-7558

Date: _____ **Patient #:** _____

Reason for Visit:

☐Received a post card ☐Received a phone call ☐New patient ☐Return visit

Patient Information:

Last Name:_____ First Name: _____Middle Initial: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ E-Mail Address: _____

Date of Birth: ____/____/_____ Age:_____ Male ☐ Female ☐ Social Security Number:_____

Single ☐Married ☐ Divorced ☐Separated ☐Widowed ☐Minor ☐

Mark all that apply: African American ☐ Caucasian ☐ Asian ☐ Hispanic ☐

American Indian-Alaskan Native ☐ Other_____ ☐

In Case of Emergency, who should be notified?_____

Phone: ( ) _____ Relationship: _____

Doctor's Name: _____ Phone number: _____

Specialty Doctor's Name: _____ Phone number: _____

Dentist's Name: _____ Phone number: _____

Insurance information

☐I have insurance coverage

☐I have no insurance coverage

Does your insurance cover immunizations? ☐Yes ☐No

Healthy Start application date applied: ____/____/_____

Primary Insurance Coverage

Name and Address of insurance company _____ Effective date____/____/_____

Name of person on card _____ SS #_____ Birth date____/____/_____

ID # on card _____ Group # on card _____

Secondary Insurance Coverage

Name and Address of insurance company _____ Effective date____/____/_____

Name of person on card _____ SS #_____ Birth date____/____/____

ID # on card _____ Group # on card _____

Employment/Income Information

Source of Income/Employer #1_____ Address _____ Phone_____

Source of Income/Employer #2_____ Address _____ Phone_____

Income: Weekly _____ Bi-weekly _____ Monthly _____ Yearly_____

Documentation provided (copy and attach) _____

☐ Please check this box if you would like information about other resources or programs offered in our community. (If you have specific needs for your family, you may list them below and a nurse will be happy to help you when you are seen)

Thank you for visiting our clinic!

Date _____ **Number in household** _____**Sliding Fee Scale Percentage**_____

Date _____ **Number in household** _____**Sliding Fee Scale Percentage**_____

Date _____ **Number in household** _____**Sliding Fee Scale Percentage**_____

Insurance/Payment Progress Notes

L:commhlth\clinic\clinicforms2015\revised 2/3/2015\to

SUMMIT COUNTY PUBLIC HEALTH
1867 West Market Street ♦ Akron, Ohio 44313-6901
Phone: (330) 923-4891 ♦ Toll-free: 1 (877) 687-0002 ♦ Fax: (330) 923-7558
www.scphoh.org

PATIENT CONTACT DIRECTIVES

Last Name: _____First Name: _____Middle Initial: _____

Date of Birth: _____/_____/_____ Phone Number (Home/Cell)_____ Language:_____

Patient Privacy Directives
In our efforts to comply with the health Insurance Portability and Accountability Act (HIPAA), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends, and co-workers.

Do we have permission to:
Contact you on your home phone or cell phone to discuss appointments, treatment or test results?
☐Yes ☐No
Leave a message on your answering machine at home regarding appointments?
☐Yes ☐☐No
Leave a message regarding appointments on your cell phone?
☐Yes ☐No
Send a message with appointment information via e-mail? (**Not guaranteed to be a secured message**)
☐Yes ☐No
Would you like us to text health information to you? (Encoded STD test results only)
☐Yes ☐No
Would you like us to share health or payment information with close friends or relatives, directly involved with your care?
☐Yes ☐No

*Please provide us with a name(s) and phone number(s) that we may leave messages regarding **appointments**:
Name:_____Number:_____(Home/Cell//Email)
Relationship to Patient
Name:_____Number:_____(Home/Cell//Email)
Relationship to Patient

*Please provide us with a name(s) and phone number(s) that we may leave a message regarding **treatments and/or test results.**
Name:_____Number:_____(Home/Cell/Email)
Relationship to Patient
Name:_____Number:_____(Home/Cell/Email)
Relationship to Patient
*Do you have any other specific instructions/requests about how we should communicate with you or others about your appointments, treatment, or test results?_____
_____
_____

I acknowledge that all information above is accurate. You must inform us **in writing** of any changes in your directives.

_____ _____ ____/____/_____
Signature Printed Name Date

TB HISTORY FORM

1867 West Market Street ♦ Akron, Ohio 44313-6901
Phone: (330) 923-4891 ♦ Toll-free: 1 (877) 687-0002 ♦ Fax: (330) 923-7558

DEMOGRAPHICS

Last name | First Name | MI | D.O.B. | M / F | Age

Address | City | County | State | Zip Code

Telephone _____/_____/_____ Client signature_____
Home Work Cell

Date _____

SKIN TEST INFORMATION

Reason for this test? School _____ Work _____ Symptoms _____ Other _____

Past TB Skin Test: Yes ____ No ____ If yes, date of test _____ Results _____

Have you received a live vaccine in the last 42 days? Yes_____ No_____

Previous Chest X-Ray? Yes ____ No ____ If yes, date of x-ray _____ Where x-ray done _____

Have you ever been exposed to someone with active TB? Yes ____ No____ If yes, When? _____

To whom were you exposed? _____

Mantoux #1 Date/time placed _____ Site _____ Man/ Lot # _____ Nurse signature _____

Date/time read _____ Result: _____ Size _____mm* Nurse signature _____

Mantoux #2 Date/time placed _____ Site _____ Man/ Lot # _____ Nurse signature _____

Date/time read _____ Result: _____ Size _____mm* Nurse signature _____

Criteria for Classifying Positive TST Reactions

Reaction of ≥ 5 mm of induration is considered positive in	**Reaction of ≥ 10 mm of induration is considered positive in**	**Reaction of ≥ 15 mm of induration is considered positive in**
• HIV-infected persons • Recent contacts of infectious TB cases • Persons with fibrotic changes on chest radiograph consistent with prior TB • Organ transplant recipients • Persons who are immunosuppressed for other reasons (e.g., taking the equivalent of > 15 mg/day of prednisone for 1 month or more, taking TNF-a antagonist	• Recent immigrants (within last 5 years) from a high-prevalence countries) • Injection drug users • Residents of employees of high risk congregate settings • Mycobacteriology laboratory personnel • Children< 4 years of age, or children or adolescents exposed to adults at high risk • Persons with clinical conditions previously mentioned	• Persons with no known risk factors for TB* *Although skin testing programs should be conducted only among high risk groups, certain individuals may require TST for employment or school attendance. An approach independent of risk assessment is not recommended by CDC or the American Thoracic Society.

If TST is 5 mm or greater, complete sections A and B

Section A: Symptom Review

Date of Interview: _____ Nurse Conducting Interview _____

Check appropriate answer

	Yes	No	Comments
Fever			
Chills			
Night Sweats			
Cough			If yes, how long has cough occurred: Is there sputum production: Is there hemoptysis:
Shortness of Breath			
Loss of appetite			
Unexplained weight loss			If yes, number of pounds in number of weeks:
Chest pain			
Smoker			

Section B Risk Factors

Check appropriate answer

	Yes	No	Comments
Contact to active TB case?			
Foreign born			
HIV positive			
Injectable drug use			
Organ transplant			
Homeless			
Diabetes			
Prolonged steroid or immunosuppressive drug use			
Silicosis			
Works in high risk facility			
Lives in high risk facility			
Chest or abdominal surgeries			

Based on symptoms, does patient need to be evaluated for acute TB infections? Yes ____ No ____

Based on risk factors, does patient meet criteria for a positive TST? Yes ____ No ____

Disposition

_____ No referral needed; does not meet criteria for positive test

_____ Refer to private physician for evaluation of TB/LTBI
Private physician name: _____

_____ Local health department for evaluation of TB/LTBI
Chest x-ray ordered: Yes ____ No ____
Physician evaluation: Yes ____ No ____

PATIENT:_____

DATE OF BIRTH:_____

VITAL SIGNS: REFERRED TO PCP_____
WT: _____TEMP:_____BP:_____/_____
PULSE:_____RESPIRATIONS:_____

Screening Checklist for Contraindications to Vaccines for Adults

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

		Yes	No	Don't Know
1.	Are you sick today?	☐	☐	☐
2.	Do you have allergies to medications, food, a vaccine component, or latex?	☐	☐	☐
3.	Have you ever had a serious reaction after receiving a vaccination?	☐	☐	☐
4.	Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder.	☐	☐	☐
5.	Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
6.	In the past 3 months, have you taken medications that weaken your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments	☐	☐	☐
7.	Have you had a seizure or a brain or other nervous system problem?	☐	☐	☐
8.	During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
9.	For women: Are you pregnant or is there a chance you could become Pregnant during the next month?	☐	☐	☐
10.	Have you received vaccinations in the past 4 weeks?	☐	☐	☐

11. List all of the prescriptions and over the counter medications you are taking and why:

_____ _____ _____

_____ _____ _____

Form completed by:_____ Date:_____

Form reviewed by: _____ Date:_____

Did you bring your immunization record with you? ☐ Yes ☐ No

Technical content reviewed by the Centers for Disease Control and Prevention www.immunize.org/catg.d/p4065.pdf • Item#P4065 (10/12)

Immunization Action Coalition • 1573 Selby Ave. • St. Paul, MN 55104 • (651) 647-9009 • www.immunize.org • www.vaccineinformation.org

Information for Health Professionals about the Screening Checklist for Contraindications To Vaccines for Adults

Are you interested in knowing why we included a certain question on the screening checklist? If so, read the information below. If you want to find out even more, consult the references listed at the bottom of this page.

1. Are you sick today? *[all vaccines]*
There is no evidence that acute illness reduces vaccine efficacy or increases vaccine adverse events (1). However, as a precaution with moderate or severe acute illness, all vaccines should be delayed until the illness has improved. Mild illnesses (such as upper respiratory infections or diarrhea) are NOT contraindications to vaccination. Do not withhold vaccination if a person is taking antibiotics.

2. Do you have allergies to medications, food, a vaccine component, or latex? *[all vaccines]*
If a person has anaphylaxis after eating gelatin, do not administer MMR or varicella vaccine. A local reaction to a prior vaccine dose or vaccine components (e.g., latex) is not a contraindication to a subsequent dose or vaccine containing that component. For a table of vaccines supplied in vials or syringes that contain latex, go to www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/latex-table.pdf. For an extensive list of vaccine components, see reference 2.
An egg-free recombinant influenza vaccine (RIV3) may be used in people age 18 years and older with egg allergy of any severity who have no other contraindications. People younger than age 18 years who have experienced a serious systemic or anaphylactic reaction (e.g., hives, swelling of the lips or tongue, acute respiratory distress, or collapse) after eating eggs can usually be vaccinated with inactivated influenza vaccine (IIV); consult ACIP recommendations (see reference 3).

3. Have you ever had a serious reaction after receiving a vaccination? *[all vaccines]*
History of anaphylactic reaction (see question 2) to a previous dose of vaccine or vaccine component is a contraindication for subsequent doses (1). Under normal circumstances, vaccines are deferred when a precaution is present. However, situations may arise when the benefit outweighs the risk (e.g., during a community pertussis outbreak).

4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder? *[LAIV]*
The safety of intranasal live attenuated influenza vaccine (LAIV) in people with these conditions has not been established. These conditions, including asthma in adults, should be considered precautions for the use of LAIV.

5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem? *[LAIV, MMR, VAR, ZOS]*
Live virus vaccines (e.g., LAIV, measles-mumps-rubella [MMR], varicella [VAR], zoster [ZOS]) are usually contraindicated in immunocompromised people. However, there are exceptions. For example, MMR vaccine is recommended and varicella vaccine should be considered for adults with CD4+ T-lymphocyte counts of greater than or equal to 200 cells/μL. Immunosuppressed people should not receive LAIV. For details, consult the ACIP recommendations (1, 4, 5).

6. In the past 3 months, have you taken medications that weaken your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments? *[LAIV, MMR, VAR, ZOS]*
Live virus vaccines (e.g., LAIV, MMR, VAR, ZOS) should be postponed until after chemotherapy or long-term high-dose steroid therapy has ended. For details and length of time to postpone, consult the ACIP statement (1, 3). To find specific vaccination schedules for stem cell transplant (bone marrow transplant) patients, see reference 6. LAIV can be given only to healthy non-pregnant people younger than age 50 years.

7. Have you had a seizure or a brain or other nervous system problem? *[influenza, Td/Tdap]*
Tdap is contraindicated in people who have a history of encephalopathy within 7 days following DTP/DTaP given before age 7 years. An unstable progressive neurologic problem is a precaution to the use of Tdap. For people with stable neurologic disorders (including seizures) unrelated to vaccination, or for people with a family history of seizure, vaccinate as usual. A history of Guillain-Barré syndrome (GBS) is a consideration with the following: 1) Td/Tdap: if GBS has occurred within 6 weeks of a tetanus-containing vaccine and decision is made to continue vaccination, give Tdap instead of Td if no history of prior Tdap; 2) Influenza vaccine (IIV/LAIV): if GBS has occurred within 6 weeks of a prior influenza vaccine, vaccinate with IIV if at high risk for severe influenza complications.

8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? *[LAIV, MMR, VAR]*
Certain live virus vaccines (e.g., LAIV, MMR, VAR, ZOS) may need to be deferred, depending on several variables. Consult the most current ACIP recommendations for current information on intervals between antiviral drugs, immune globulin or blood product administration and live virus vaccines. (1)

9. For women: Are you pregnant or is there a chance you could become pregnant during the next month? *[MMR, LAIV, VAR, ZOS]*
Live virus vaccines (e.g., MMR, VAR, ZOS, LAIV) are contraindicated one month before and during pregnancy because of the theoretical risk of virus transmission to the fetus. Sexually active women in their childbearing years who receive live virus vaccines should be instructed to practice careful contraception for one month following receipt of the vaccine. On theoretical grounds, inactivated poliovirus vaccine should not be given during pregnancy; however, it may be given if risk of exposure is imminent and immediate protection is needed (e.g., travel to endemic areas). Use of Td or Tdap is not contraindicated in pregnancy. At the provider's discretion, either vaccine may be administered during the 2nd or 3rd trimester. (1, 3, 4, 5, 7, 8)

10. Have you received any vaccinations in the past 4 weeks?
[LAIV, MMR, VAR, yellow fever] People who were given either LAIV or an injectable live virus vaccine (e.g., MMR, VAR, ZOS, yellow fever) should wait 28 days before receiving another vaccination of this type. Inactivated vaccines may be given at any spacing interval if they are not administered simultaneously.

References:
1. CDC. General recommendations on immunization, at www.cdc.gov/vaccines/pubs/acip-list.htm
2. Table of Vaccine Components: www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/excipient-table-2.pdf.
3. CDC. Prevention and control of seasonal influenza with vaccines: Recommendations of the ACIP—2014–2015 Influenza Season at www.cdc.gov/mmwr/pdf/wk/mm6332.pdf, pages 691–7.
4. CDC. Measles, mumps, and rubella—vaccine use and strategies for elimination of measles, rubella, and congenital rubella syndrome and control of mumps. *MMWR* 1998; 47 (RR-8).
5. CDC. Prevention of varicella: Recommendations of the Advisory Committee on Immunization Practices. *MMWR* 2007; 56 (RR-4).
6. Tomblyn M, Einsele H, et al. Guidelines for preventing infectious complications among hematopoietic stem cell transplant recipients: a global perspective. *Biol Blood Marrow Transplant* 15:1143–1238; 2009 at www.cdc.gov/vaccines/pubs/hematocell-transplts.htm.
7. CDC. Notice to readers: Revised ACIP recommendation for avoiding pregnancy after receiving a rubella-containing vaccine. *MMWR* 2001; 50 (49).
8. CDC. Prevention of pertussis, tetanus, and diphtheria among pregnant and postpartum women and their infants: Recommendations of the ACIP. *MMWR* 2008; 57 (RR-4).

Summit County Public Health
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Form 2

1867 West Market Street ♦ Akron, Ohio 44313-6901
Phone: (330) 923-4891 ♦ Toll-free: 1 (877) 687-0002 ♦ Fax: (330) 923-7558
www.scphoh.org

Please have the client complete this cover sheet and then remove it and place it in the client's medical record.

I, _____, agree that I have received the August 2013 Notice of Privacy Practices.

_____ _____

Client or Client Guardian Signature **Date**

FOR INTERNAL USE ONLY

☐ **Client refused signature**

Clerical Specialist Initials ☐ **Date** ___/___/_____

1867 West Market Street • Akron, Ohio 44313-6901
Phone: (330) 923-4891 • Toll-free: 1 (877) 687-0002 • Fax: (330) 923-7558
www.scphoh.org

NOTICE OF PRIVACY PRACTICES
FOR THE
USE AND DISCLOSURE OF PRIVATE HEALTH INFORMATION

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.
Effective Date: 9/23/2013

The Summit County Combined General Health District (District) is required by law to maintain the privacy of Protected Health Information (PHI) and to provide individuals with notice of our legal duties and privacy practices with respect to PHI. PHI is information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. This Notice of Privacy Practices (Notice) describes how we may use and disclose PHI to carry out treatment, payment or health care operations and for other specified purposes that are permitted or required by law. This Notice also describes your rights with respect to PHI about you.
The District is required to follow the terms of this Notice. We will not use or disclose PHI about you without your written authorization, except as described in this Notice. We reserve the right to change our practices and this Notice, and to make the new Notice effective for all PHI we maintain. Upon request, we will provide any revised Notice to you.

NOTICE OF PHI USES AND DISCLOSURES

Required PHI Uses and Disclosures
Upon your request, the District is required to give you access to certain PHI in order to inspect and copy it. Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the District's compliance with the privacy regulations.

Uses and disclosures to carry out treatment, payment, and health care operations
The District and its business associates will use PHI without your consent, authorization or opportunity to agree or object to carry out treatment, payment and health care operations.

a) **Treatment** is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers.
For example, the District may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental X-rays from the treating dentist.

b) **Payment** includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and pre-authorizations).
For example, the District may tell an insurance carrier that you received certain services from the district in order to receive insurance payments. (Exception: if you receive services from the District and pay in full without using insurance, you may request that the District not disclose any record of that treatment to your insurer).

c) **Health care operations** include but are not limited to quality assurance and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities.

For example, the District may use information about your claims to refer you to a disease management program, project future benefit costs or audit the accuracy of its claims processing functions.

If PHI is used or disclosed for underwriting purposes, the District is prohibited from using or disclosing any of your PHI that is genetic information for such purposes.

Uses and disclosures that require your express written authorization

Your written authorization generally will be obtained before the District will use or disclose psychotherapy notes about you from your psychotherapist. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. (They do not include summary information about your mental health treatment, such as diagnoses and prescription information.) However, the District will not require your express written authorization to use and disclose such notes: where used by the originator of the psychotherapy notes; where used in mental health training programs; where needed by the District to defend against litigation filed by you; and to send to appropriate oversight agencies.

In addition, your written authorization will be obtained for uses and disclosures of PHI for marketing purposes and disclosures that constitute a sale of PHI.

Uses and disclosures that require that you be given an opportunity to agree or disagree prior to their use or release

If you have had the opportunity to object and have not told the District that you object to the following uses of PHI, the District may disclose your PHI under the following circumstances:

- To disclose your PHI to family members, other relatives and your close personal friends if the information is directly relevant to the family or friend's involvement with your care or payment for that care, and
- To disclose your PHI for disaster relief purposes.

Uses and disclosures for which consent, authorization or opportunity to object is not required

Use and disclosure of your PHI is allowed without your consent, authorization or request under the following circumstances:

1. When required by law.

2. When permitted for purposes of public health activities, including when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.

3. When authorized by law to report information about abuse, neglect, or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the District will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose or reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.

4. The District may disclose your PHI to a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

5. The District may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the District that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.

6. When required for law enforcement purposes (for example, to report certain types of wounds).

7. For law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to be a victim of a crime but only if the individual agrees to the disclosure or the District is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the District's best judgment.

8. When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

9. The District may use or disclose PHI for research, subject to conditions.

10. When consistent with applicable law and standards of ethical conduct if the District, in good faith, believes 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 and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

11. When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

    Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke such authorization.

RIGHTS OF INDIVIDUALS

Right to Request Restrictions on PHI Uses and Disclosures

You may request the District to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the District is not required to agree to your request.
The District will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations.
You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI.
Such requests should be made to the following officer: Lesley A. Walter, Summit County Health District, 1100 Graham Road Circle, Stow, OH 44224, (330) 926-5738.

Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set", for as long as the District maintains the PHI. You must request to inspect or copy your designated record set in writing. You do not have a right of access to the following: (i) Psychotherapy notes;(ii) Information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding; and (iii) Protected health information maintained by a covered entity that is:(A) Subject to the Clinical Laboratory Improvements Amendments of 1988, 42 U.S.C. 263a, to the extent the provision of access to the individual would be prohibited by law; or (B) Exempt from the Clinical Laboratory Improvements Amendments of 1988, pursuant to 42 CFR 493.3(a)(2).

- **Protected Health Information** (PHI) includes all individually identifiable health information transmitted or maintained by the District, regardless of form.
- **Designated Records Set** includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the Covered Entity to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The requested information will be provided in paper form within 30 days. A single 30-day extension is allowed if the District is unable to comply with the deadline. The District may impose reasonable, cost-based charges for paper copies. Electronic copies may be transmitted to you via email, but you accept the risk that such transmissions will not be secure.
You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made to the following officer: Lesley A. Walter, Summit County Health District, 1100 Graham Road Circle, Stow, OH 44224, (330) 926-5738.

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise review rights (if they apply) and a description of how you may complain to the Secretary of U.S. Department of Health and Human Services.

Right to Amend PHI

You have the right to request the District to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set.
The District has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the District is unable to comply with the deadline. If the request is denied in whole or part, the District must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.
Requests for amendment of PHI in a designated record set should be made to the following officer: Lesley A. Walter, Summit County Health District, 1100 Graham Road Circle, Stow, OH 44224, (330) 926-5738.
You or your personal representative will be required to complete a form to request amendment of the PHI in your designated record set.

The Right to Receive an Accounting of PHI Disclosures

At your request, the District will provide you with an accounting of disclosures by the District of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made:

1. To carry out treatment, payment or health care operations;
2. To individuals about their own PHI;
3. Prior to the compliance date; or,
4. Based on your written authorization.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the District will charge a reasonable, cost-based fee for each subsequent accounting.

The Right to Receive a Paper Copy of This Notice Upon Request

To obtain a paper copy of this Notice contact the following officer: Lesley A. Walter, Summit County Health District, 1100 Graham Road Circle, Stow, OH 44224, (330) 926-5738.

The Right to Be Notified of a Breach of Unsecured PHI

The District is required by law to notify you following a breach of any Unsecured PHI.

The Right to Revoke an Authorization Releasing PHI

You may exercise the right to revoke an authorization releasing your PHI at any time.

A Note about Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- a power of attorney for health care purposes, notarized by a notary public;
- a court order of appointment of the person as the conservator or guardian of the individual; or,
- an individual who is the parent of a minor child.

The District retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

THE DISTRICT'S DUTIES

The District is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of its legal duties and privacy practices.

This Notice is effective beginning (9/23/2013) and the District is required to comply with the terms of this Notice. However, the District reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the District prior to that date. If a privacy practice is changed, a revised version of this Notice will be provided upon request to all past and present participants and beneficiaries for whom the District still maintains PHI. Any revised Notices shall be posted in a prominent place accessible to the public and on the District's website.

Any revised version of this Notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the District or other privacy practices stated in this notice.

Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another Covered Entity, the District will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

- disclosures to or requests by a health care provider for treatment;
- uses or disclosures made to the individual;
- disclosures made to the Secretary of the U.S. Department of Health and Human Services;
- uses or disclosures that are required by law; and,
- uses or disclosures that are required for the District's compliance with legal regulations.

This Notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is to reasonable basis to believe that the information can be used to identify an individual is not individually identifiable health information.

In addition, the District may use or disclose "summary health information" in circumstances where identifying information has been deleted in accordance with HIPAA.

YOUR RIGHT TO FILE A COMPLAINT WITH THE DISTRICT OR THE HHS SECRETARY

If you believe that your privacy rights have been violated, you may complain to the District in care of the following officer: Lesley A. Walter, Summit County Health District, 1100 Graham Road Circle, Stow, OH 44224, (330) 926-5738.

You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201.

The District will not retaliate against you for filing a complaint.

WHOM TO CONTACT AT THE DISTRICT FOR MORE INFORMATION

If you have any questions regarding this notice or the subjects addressed in it, you may contact the following officer: Lesley A. Walter, Summit County Health District, 1100 Graham Road Circle, Stow, OH 44224, (330) 926-5738.