

# **CEDAR CREST**

## **Joint 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.**

### **Our Legal Duty**

We are required by both federal and state law to maintain the privacy of your protected health information. We are also required to provide you with our Notice of Privacy Practices describing our legal duties, privacy practices and your rights with respect to your protected health information. This notice takes effect **April 14, 2003** and will remain in effect until we replace it.

Cedar Crest (Cedar Crest Hospital, Residential Treatment Center and Cedar Crest Clinic) and its employees, professional staff and volunteers must follow the privacy practices described in this Notice while it is in effect. We reserve the right to change our privacy practices and the terms of this Notice at any time, as long as these changes are permitted by law. If we revise our Notice, we will follow the terms of the revised Notice as long as it is currently in effect. Before we make any significant changes in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time from the contact person listed at the end of this Notice.

### **Uses and Disclosures of Your Health Information**

As required by law, Cedar Crest maintains your health information in a confidential manner. However, we must use and disclose your health information to the extent necessary to provide you with quality care. To do this, we must share your health information as necessary for treatment, payment and health care operations.

**Treatment:** This includes sharing information among health care providers involved in your care. For example: We may disclose health information about you to other health care professionals who are involved in taking care of you.

Cedar Crest physicians are “covered entities” under the law who may have access to your health information based on their role as your attending or consulting physician.

**Payment:** This includes sharing information for payment purposes. For example: We may use your health information as required by your insurer to obtain payment for your treatment or hospital stay.

**Health Care Operations:** This includes sharing information in connection with our health care operations. For example: Health care operations may include, but are not limited to, process improvement activities, evaluating health care provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Persons Involved in Your Care:** We may release health information to the person responsible for your care or payment for your treatment, a family member, or your personal representative. If you are able and available to agree or object, we will give you the opportunity to object prior to disclosing any information. If you are unable or unavailable to agree or object, our health professionals will use their best judgment on disclosing only relevant health information.

**Appointment Reminders:** We may use and disclose health information to contact you as a reminder that you have an appointment at Cedar Crest.

**Public Health Activities:** Public Health Activities may include: disease prevention; injury or disability; reporting births and deaths; reporting child abuse or neglect; reporting reactions to medications or product recalls; infectious disease control; notifying government authorities of suspected abuse, neglect, or domestic violence (if you agree or as required by law).

**As Required by Law:** We may use and disclose your health information as required by law, subpoena, or other legal process.

**Fundraising Activities:** We may use limited health information about you to contact you in an effort to raise money for Cedar Crest and its operations. You will have an opportunity to refuse to receive these communications.

**Coroners, Medical Examiners, and Funeral Directors:** In order to carry out their lawful duties, health information may be disclosed to coroners, medical examiners, and funeral directors.

**Governmental Disclosures:** Under certain circumstances we may disclose health information of Armed Forces personnel to military authorities. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose health information about inmates to correctional institutions or law enforcement officials having lawful custody.

**Your Authorization:** Except as described above, we will not use or disclose your health information unless you authorize Cedar Crest in writing to disclose your health information. You may revoke this authorization in writing at any time. Your revocation will be effective only after the date Cedar Crest receives your revocation. This revocation will not affect any use or disclosures permitted by your authorization while it was in effect.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

#### **Patient Rights**

**Access:** You have the right to inspect and copy your health information, with limited exceptions. You must make a request in writing to obtain access to your health information. Cedar Crest may charge a reasonable fee for copying and mailing.

**Request Restrictions:** You may request limitations on our use or disclosure of your health information. This request must be in writing and specify the limitations being requested. Cedar Crest is not required to agree to your request, but if we do agree, we will abide by the agreement.

**Request Alternative Communications:** You have the right to request that we communicate with you about your health information in alternative means or locations. For example, you may ask that we only contact you by telephone at work or that we only contact you by mail at home. Your request must be in writing and specify how or where you wish to be contacted. All reasonable requests will be accommodated.

**Amendment:** If you believe that the health information we have about you is incorrect or incomplete, you have the right to request that we amend your health information. This request must be in writing and explain why the information should be amended. Cedar Crest is not required to accept the amendment.

**Accounting of Disclosures:** You have the right to request a list of the disclosures of your health information that have been made to persons or entities other than for treatment, payment or health care operations, and certain other activities, for the past six years, but not before April 14, 2003. If you request this accounting more than once in a 12 month period, we may charge you for the costs of providing the list.

**Electronic Notice:** You have the right to a paper copy of this Notice.

#### **Questions and Complaints**

If you want more information about our privacy practices, have a request concerning your patient rights, or have any questions or concerns, please contact us at the addresses listed below.

If you are concerned that we may have violated your rights or you disagree with a decision we have made regarding a request you submitted to us, you may contact us using the contact information located at the end of this form. You may also submit a written complaint to the Department of Health and Human Services. We will provide you with the address to file your complaint with the Department of Health and Human Services upon request.

We support your right to the privacy of your health information. You will not be penalized or retaliated against in any way for making a complaint to Cedar Crest or to the Department of Health and Human Services.

#### **Contacts**

**Privacy Officer**  
3500 S. IH-35  
Belton, TX 76513  
(254) 939-2100

**BY SIGNING THIS ACKNOWLEDGEMENT, YOU ARE SIMPLY INDICATING THAT YOU HAVE RECEIVED CEDAR CREST'S NOTICE OF PRIVACY PRACTICES. YOU ARE NEITHER CREATING NOR WAIVING ANY OF YOUR PATIENT RIGHTS.**

Patient Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient (if 18 or older)      Date  
or Legal Guardian (if patient is  
under 18)