Macoupin County Public Health Department
Notice of Privacy Acknowledgement

I, ____________________________, acknowledge that I have received from Macoupin County Health Department a copy of the Privacy Notice. I understand it is my responsibility to read the notice and if needed ask questions.

_______________________________________ ______________________
Patient Signature/Patient Representative Date

_______________________________________ ______________________
Relationship to Patient Date

_______________________________________ ______________________
Witness Date

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**Consent to Release Information to Designated Family Member or Caregiver**

The names listed below are allowed to have information released to them from Macoupin County Public Health Department with the undersigned consent.

_______________________________________ ______________________
Name to receive information & relationship Information **not** to release

_______________________________________ ______________________
Name to receive information & relationship Information **not** to release

_______________________________________ ______________________
Name to receive information & relationship Information **not** to release

This consent remains in effect for one (1) year period and will be updated and signed on a yearly basis or as needed per patient request. This consent may be revoked at any time upon written request.

Signed _______________________________________ Date__________________

Address ____________________________________________________________

City_______________________________ State ___________ Zip Code __________

Signed _______________________________________ Date ____________________

Signed _______________________________________ Date ____________________

**Acknowledgment of Receipt of Notice of Privacy Practices**

**MACOUPIN COUNTY PUBLIC HEALTH DEPARTMENT**

This is to acknowledge my receipt of MACOUPIN COUNTY PUBLIC HEALTH DEPARTMENTS's Notice of Privacy Practices (effective date: 4/14/2003).

______________________________
Date of Patient's or Personal Representative's Signature

______________________________
Signature of Patient or Personal Representative

______________________________
Patient's Name

______________________________

______________________________
Patient's Address

______________________________
Name of Personal Representative
(If applicable)

______________________________

______________________________
Description of Representative's Authority to
Act for the Patient
(If applicable)

Program__________________________

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# MACOUPIN COUNTY PUBLIC HEALTH DEPARTMENT
## NOTICE OF PRIVACY PRACTICES
## 04/14/03

OUR PLEDGE TO YOU:

We understand that medical information about you is personal. We are committed to protecting medical information about you. We create a patient record on you at your first visit to our office to provide quality care and to comply with legal requirements. We are required by law to:

- Keep medical information about you private.
- Give you this notice of our legal duties and privacy practices with respect to medical information about you.
- Follow the terms of the notice that are currently in effect.

CHANGES TO THIS NOTICE:

We may change our policies at any time. Changes will apply to medical information we already hold, as well as new information after the change occurs. Before we make a significant change in our policies, we will post the new notice in our waiting areas and on our web site (www.mcphd.net). You can receive a copy of the current notice at any time. The effective date of the current policy will be listed on the document. You will be offered a copy of the current notice at your next visit to our office. You will be asked to acknowledge, in writing, your receipt of this notice.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU:

We may use and disclose your medical information to provide, coordinate, or manage your care and related services. Examples of such uses would be for referral to a doctor for treatment, referral to an insurance company for payment for treatment, or to support the health care operations of our office, such as review of services by an accountant. We may contact you to remind you of your appointment and we may call you by name from our waiting room.

USES WITHOUT YOUR AUTHORIZATION:

We may use and disclose information about you without your prior authorization for several reasons. Subject to certain requirements, we may give out medical information about you without prior authorization to report abuse or neglect, as required by law, for public health purposes, health care oversight, worker's compensation, military, national security, protective services for the President, security clearances, inmates or medical emergencies.

INDIVIDUALS INVOLVED IN YOUR CARE:

We may disclose to a family member, a close friend, or any other person identified by you, medical information that is relevant to that person's involvement in your care or payment related to your care.

OTHER USES OF MEDICAL INFORMATION:

In any other situation not covered by this notice, we may disclose your health information, but you will have an opportunity to give written authorization to the use and disclosure of all or part of your health information. If you are not present or able to give authorization, we may determine whether disclosure is in your best interest. If you agree to this release of information, you may revoke that decision at any time by notifying us, in writing, of your decision.

You have the right to a list of those instances where we have disclosed medical information about you, other than for treatment, payment, health care operations, or where you specifically authorized a disclosure. You may be charged for this information according to our cost of producing the list.

**MACOUPIN COUNTY PUBLIC HEALTH DEPARTMENT**
**805 N. Broad Street**
**Carlinville, Il 62626**
**Phone: 217-854-3223**
**Fax: 217-854-3225**

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU:
YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU:
You have the right, with certain exceptions, to inspect and copy your health information; however, we may charge a fee to cover the cost of copying, mailing, or other related supplies. You must make this request in writing. You have the right to request that we amend your medical record by submitting a request in writing that provides your reason for requesting the amendment. We could deny your request to amend a record if the information was not created by us, if it is not part of the medical information maintained by us, or if we determine that the record is accurate. You may appeal, in writing, a decision by us not to amend a record.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS: HOW WE WILL CONTACT YOU:
You have the right to request that medical information about you be communicated to you in a certain way or at a certain location such as sending mail to an address other than your home, by notifying us in writing of the specific way or location for us to use to communicate with you. We will accommodate your request. However, we may, when appropriate, require information from you concerning how payment will be handled. We may also request an alternative address or alternate method by which we may contact you.

RIGHT TO REQUEST RESTRICTIONS:
You may request, in writing, that we not use or disclose medical information about you for treatment, payment, or health care operations or to persons involved in your care except when specifically authorized by you, when required by law or in an emergency. You may be held responsible for payment of your charges if the balance is unpaid due to your restrictions.

*WE ARE NOT REQUIRED TO AGREE TO ANY RESTRICTIONS.*

COMPLAINTS:
If you are concerned that your privacy rights may have been violated, or you disagree with a decision we made about access to your records, you may contact our Privacy Officer by calling (217-854-3223) or by writing to 805 N. Broad St., Carlinville, IL 62626. In addition, you may send a written complaint to the U.S. Department of Health and Human Services Offices of Civil Rights. Our Privacy Officer can provide you with the address. Under no circumstances will you be penalized or retaliated against for filing a complaint.

*Thank you for the opportunity to provide for your health care needs.*
*Under no circumstances will you be penalized or retaliated against for filing a complaint.*
*Thank you for the opportunity to provide for your health care needs.*

*You have the right to receive a copy of our Notice of Privacy Practices by contacting the Privacy Officer at the address below:*

*PRIVACY OFFICER*
805 N. Broad Street
Carlinville, IL
62626
217-854-3223