



# GRANT REGIONAL HEALTH CENTER

## Notice of Privacy Practices

This notice has been adopted by **GRANT REGIONAL HEALTH CENTER, INC.**, 507 South Monroe Street, Lancaster, WI 53813.  
Grant Regional Health Center is an acute care hospital with surgical, swing bed, emergency, rehabilitation, monitored bed, obstetrical, specialty clinic and primary care clinic.

We shall participate and agree to abide by the terms of the notice currently in effect with respect to health information created or received by the hospital.  
**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.**  
Grant Regional Health Center (hereinafter referred to as hospital) is required to maintain the privacy of your health information and provide you with a Notice that describes the hospital's legal obligations and privacy practices described in this Notice. If you have questions about any part of this Notice or if you want more information about the privacy practices, please refer to the below contact information.

**Contact Information:** If you have any questions or concerns regarding your privacy rights or the information in this Notice, please contact the Privacy Officer at  
Grant Regional Health Center, 507 S. Monroe Street, Lancaster, WI 53813. The Privacy Officer may be contacted at telephone number (608) 723-1393 or email at [privacyofficer@grantregional.com](mailto:privacyofficer@grantregional.com).

### OUR OBLIGATION REGARDING YOUR MEDICAL INFORMATION

We understand that health information about you and your health is personal. We are committed to protecting the privacy of your health information.

This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of your health information.

Protected health information applies to all health care information written, spoken, and electronic, including those on which written, drawn, printed, spoken, visual, electro-magnetic or digital information is recorded or preserved, regardless of physical characteristics or form.

We reserve the right to change the privacy practices described in this notice in the event that the practices change to comply with law. If we change our privacy practices, you will receive a revised copy at your next visit.

### **We Are Required By Law To:**

- Protect the privacy of your health information;
- Give you this Notice of our legal obligation and privacy practices regarding your health information;
- Follow the terms of our Notice that is currently in effect.

### How We May Use & Disclose Your Medical Information:

The following categories describe the ways that we use or disclose health information. For each category of uses or disclosures, we will explain what we mean and give examples. Not every conceivable use or disclosure will be listed.

**Treatment.** We may use or disclose your health information in the provision, coordination or management of your health care. We may use information to call and remind you of an appointment or refer your care to another physician. If another provider requests your health information and they are not providing care and treatment to you, we will request an authorization from you before providing your information.

**Payment.** We may use or disclose your health care information to obtain payment for health care services. For example, we may use your information to send a bill for your health care services to your insurer or tell your insurer about a treatment or service you are going to receive to obtain their prior approval.

**Health Care Operations.** We may use or disclose your health care information for activities relating to the evaluation of patient care, evaluating the performance of health care providers, business planning and compliance with the law. For example, we may use your information to determine the quality of care you received when you had your surgery. If activities require disclosure of your health care information outside of the hospital, we will request your authorization before disclosure.

### How We May Use or Disclose Your Health Information Without Your Written Authorization:

**Required by Law.** We may use and disclose your health information when that use or disclosure is required by law. For example, we may disclose medical information to report child abuse or to respond to a court order.

**Public Health.** When required by law, we may disclose your health information to public health authorities for reporting communicable diseases, aiding in the prevention or control of certain diseases and reporting problems with products and reactions to medications to the Food and Drug Administration.

**Victims of Abuse, Neglect or Violence.** We may disclose your information to a government authority authorized by law to receive reports of abuse, neglect or violence relating to children or the elderly.

**Health Oversight Activities.** We may disclose your health information to health agencies authorized by law to conduct audits, investigations, inspections, licensure validation and other proceedings related to oversight of the health care system.

**Judicial and Administrative Proceedings.** We may disclose your health information in the course of an administrative or judicial proceeding in response to a court order. Generally, when the request is made through a subpoena, a discovery request or another type of administrative order, your authorization will be obtained before disclosure is permitted.

**Law Enforcement.** We may disclose your health information to a law enforcement official for purposes of identifying or locating a suspect, fugitive, or missing person, or to comply with a court order or other law enforcement purposes. In some circumstances, we will request your authorization prior to permitting disclosure.

**Coroners and Medical Examiners.** We may disclose your health information to coroners and medical examiners. For example, this may be necessary to determine the cause of death.

**Organ, Eye or Tissue Donation.** We may disclose your health information to organizations involved in procuring organs and tissue for transplantation.

**Health Related Opportunities.** We may use or disclose your health information to provide you information about treatment alternatives or other health-related benefits or services that may be of interest to you.

**To Avert a Serious Threat to Health or Safety.** We may disclose your health information, with discretion, to appropriate persons to prevent a serious threat to the health or safety of another or the general public. Generally disclosure is to law enforcement personnel who are involved in protecting the public safety.

**Specialized Government Functions.** In certain and limited circumstances, we may disclose your health care information for military, national security or law enforcement custodial situations.

**Workers' Compensation.** Both state and federal law allow the disclosure of your health care information that is reasonably related to a worker's compensation injury to be disclosed without your authorization. These programs may provide you benefits for work-related injuries or illness.

**Fundraising Activities.** We may disclose limited information to the hospital foundation to contact you for fundraising for the hospital and its operations. You have the right to opt out of receiving fundraising communications.

**Hospital Census.** We may include limited information about you in the hospital census while you are a patient at the hospital. This may include your name, location in the hospital, and religious affiliation. Census information may also be disclosed to people who ask for you by name so your family, friends and clergy can visit you in the hospital. Your religious affiliation may be given to a member of the clergy, such as a priest. If you do not want to be listed in the census or for your census information to be disclosed, you must notify the Social Services Office or the Admissions Department in writing.

### When Grant Regional Health Center May Not Use or Disclose Your Health Information.

Except as described in this Notice, we will not use or disclose your health information without your written authorization. If you do authorize us to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time. If you revoke your authorization, we will no longer be able to use or disclose health information about you for the reasons covered by your written authorization. We will be unable to take back disclosures we have already made with your permission.

**Individuals Involved in Your Care or Payment for Your Care.** We may release medical information directly about you to a family member, relative, close friend or other person identified by you who is involved in your medical care and/or helps pay for your care. We also may disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

**Research.** Under certain circumstances, and only after a special approval process, we may use or disclose your health information to conduct research which may involve an assessment of how well a drug is working to cure a heart disease or whether a certain treatment is working better than another.

**Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official, (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

**Psychotherapy Notes.** Authorization is required for use and disclosures of your health information in relation to psychotherapy services.

**Genetic Information.** Authorization is required for use/disclosure of genetic information for underwriting purposes.

**Marketing.** Authorization is required for use/disclosure of your health information for hospital marketing purposes.

**Paid Out-of-Pocket.** Disclosures of your health information to your health plan will be restricted in the event that you have paid your item/service out of pocket and in full.

### OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of health information not covered by this Notice or the laws that apply to us will be made only with your written permission. When your medical information is used or disclosed pursuant to an authorization and other reasons permitted by law, it may be subject to re-disclosure by a person who receives your medical information. This disclosure may not be protected by the applicable privacy law. (i.e., if the recipient of your medical information is not a health care provider, health plan or healthcare clearing house and not governed by state or federal law),

### YOUR HEALTH INFORMATION RIGHTS

You have the following rights regarding health information we maintain about you:

**Request Restrictions on Certain Uses and Disclosures.** You have the right to request restrictions on how your health information is used or to whom your information is disclosed even if the restriction affects your treatment or our payment or health care operation activities. For example, you could ask that we not use or disclose information about a surgery you had to a family member or friend.

We are not required to agree to your requested restriction. To request restrictions, your request must be in writing to the Admissions Director. Your request must include (1) what information you want to restrict; (2) whether you want to restrict use, disclosure or both; and (3) to whom you want the restrictions to apply, for example, disclosures to your spouse.

**Receive Confidential Communications of Health Information.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can request to receive information about your health status in a private room or through a written letter sent to a private address. We must accommodate reasonable requests. To request confidential communications, you must make your request in writing to the Admissions Director. Your request must specify how and where you wish to be contacted.

**Inspect and Copy Your Health Information.** You have the right to inspect and obtain a copy of your health care information. For example, you may request a copy of your immunization record from your health care provider. This right of access does not apply to psychotherapy notes maintained for the personal use of a mental health professional. Your request for inspection or access must be submitted in writing to the Director of Health Information Management. If you request a copy of the information, we may charge a fee for the costs of copying or other supplies associated with your request and will provide you with access and/or copies within 30 days.

We may deny your request to inspect and obtain a copy of your health information in certain circumstances. You may request that the denial be reviewed. Another licensed health care professional chosen by the hospital, but not the person who denied your request, will conduct a review. We will comply with the outcome of the review.

**Request To Correct Your Health Information.** You have a right to request that Grant Regional Health Center amend your health information that you believe is incorrect or incomplete. For example, if you believe the date of your heart surgery is incorrect, you may request that the information be corrected. We are not required to change your health information and if your request is denied, we will provide you with information about our denial and how you can disagree and request an amendment in writing. The request must include a reason for the request and be submitted to the Director of Health Information Management.

### Requesting Lab Results

Effective April 7, 2014, you have the right to direct access to laboratory test reports. To receive results, you may go directly to Grant Regional Health Center Laboratory and request your results. We will require you to sign Authorization for Disclosure that will be in effect for up to one year from signing if you choose. We will then be able to provide you with your lab results upon your request. We will require a new disclosure to be signed each year if you choose to continue to receive lab results on a regular basis. Authorization for disclosure may also be designated for a specific one-time receipt of result.

**Receive A Record of Disclosures of Your Health Information.** You have the right to request a list of the disclosures of your health information we made in compliance with federal and state law. This list, called an "accounting of disclosures" will include the disclosure date, to whom, a brief description, and for what purpose. To request this list or accounting, you must submit your request in writing to the Director of Health Information Management. Your request must state:

- a time period which may not be longer than six years;
- may not include dates before April 14, 2003; and
- in what format you want the list (on paper, electronically).

The first request within a 12-month period will be free. For additional lists, we will charge you the costs of providing the list. We will notify you of the cost involved and you may withdraw or modify your request at that time before any costs are incurred.

We must comply with your request for an accounting within 60 days, unless you agree to a 30-day extension.

**Breach Notification.** You have the right to be notified when any breach has occurred of your unsecured protected health information.

**Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice, and you may request a copy at any time. To obtain a paper copy of this Notice, send your written request to the Admissions Department. You may also obtain a copy of this notice at our Website, [www.grantregional.com](http://www.grantregional.com).

### COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the hospital in writing to the Privacy Officer that will provide you with any needed assistance or call (608)723-1393. You may also file a complaint with the Office of Civil Rights, Region V, U.S. Department of Health and Human Services., 233 N. Michigan Avenue, Suite 240, Chicago, IL 60601. Voice phone: 1-800-368-1019. TDD 1-800-537-7697. There will be no retaliation against you in any way for filing a complaint.



# GRANT REGIONAL COMMUNITY CLINIC

## Notice of Privacy Practices

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We reserve the right to change the privacy practices described in this notice in the event that the practices change to comply with law. If we change our privacy practices, you will receive a revised copy at your next visit.

### **We Are Required By Law To:**

- Protect the privacy of your health information;
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**Payment.** We may use or disclose your health care information to obtain payment for health care services. For example, we may use your information to send a bill for your health care services to your insurer or tell your insurer about a treatment or service you are going to receive to obtain their prior approval.

**Health Care Operations.** We may use or disclose your health care information for activities relating to the evaluation of patient care, evaluating the performance of health care providers, business planning and compliance with the law. For example, we may use your information to determine the quality of care you received when you had your surgery. If activities require disclosure of your health care information outside of the hospital, we will request your authorization before disclosure.

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### **OTHER USES OF MEDICAL INFORMATION**

Other uses and disclosures of health information not covered by this Notice or the laws that apply to us will be made only with your written permission. When your medical information is used or disclosed pursuant to an authorization and other reasons permitted by law, it may be subject to re-disclosure by a person who receives your medical information. This disclosure may not be protected by the applicable privacy law. (i.e., if the recipient of your medical information is not a health care provider, health plan or healthcare clearing house and not governed by state or federal law),

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### **Requesting Lab Results**

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**Receive A Record of Disclosures of Your Health Information.** You have the right to request a list of the disclosures of your health information we made in compliance with federal and state law. This list, called an "accounting of disclosures" will include the disclosure date, to whom, a brief description, and for what purpose. To request this list or accounting, you must submit your request in writing to the Director of Health Information Management. Your request must state:

- a time period which may not be longer than six years;
- may not include dates before April 14, 2003; and
- in what format you want the list (on paper, electronically).

The first request within a 12-month period will be free. For additional lists, we will charge you the costs of providing the list. We will notify you of the cost involved and you may withdraw or modify your request at that time before any costs are incurred.

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