CITY OF MADISON
PRIVACY PRACTICES NOTICE

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. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your medical information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your medical information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect June 1, 2013, and will remain in effect unless we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all medical information that we maintain, including medical information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice, post the revised notice at each of our service delivery sites, and make the new notice available to our patients and others upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information at the end of this notice.

If there is an unauthorized acquisition, access, use or disclosure or your medical information that is a result of unreasonable safeguards and said breach poses a significant risk of financial, reputational or other harm to you, we will notify you of said breach, within 60 days of when we become aware of said breach.

Uses and Disclosures of Medical Information

Treatment: We may use your medical information, without your permission, to treat you. We may disclose your medical information, without your permission, to a physician or other health care provider for your treatment. When we transport you to a hospital we may disclose your health information for treatment purposes.

Payment: We may use and disclose your medical information, without your permission, to obtain or provide reimbursement for health care we provide to you or for health care you have received. If we bill Medicaid or Medicare for reimbursement, we will submit an electronic claim that includes your name and other personal information.

Health Care Operations: We may use and disclose your medical information for certain of our health care operations. Health care operations include:

- health care quality assessment and improvement activities;
- reviewing and evaluating health care provider and health plan performance, qualifications and competence, health care training programs, health care provider and health plan accreditation, certification, licensing and credentialing activities;
- conducting or arranging for medical reviews, audits, and legal services, including fraud and abuse detection and prevention; and
- business planning, development, management, and general administration, including customer service, de-identifying medical information, and creating limited data sets for health care operations, public health activities, and research.

Your Authorization: We must receive your written authorization before we disclose any psychotherapy notes; before we share your information for marketing purposes or before we sell any of your protected health information. You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we will not use or disclose your medical information for any purpose other than those described in this notice.

Patient Contact: We may use your medical information to contact you via telephone or mail to discuss billing information.

Public Health and Benefit Activities: We may use and disclose your medical information, without your permission, when required by law and in the following situations:

- for public health, including to report communicable disease, child abuse, and adult abuse, neglect or domestic violence;
- to avert a serious and imminent threat to health or safety;
- for health care oversight, such as activities of state licensing and peer review authorities, and fraud prevention enforcement agencies;
- to coroners, medical examiners and funeral directors;
- as authorized by state worker's compensation laws;
- in response to court and certain administrative orders and other lawful process;
- to law enforcement officials with regard to crime victims, crimes on our premises, crime reporting in emergencies, and identifying or locating suspects or other persons;
- to the military, to federal officials for lawful intelligence, counterintelligence, and national security activities, and to correctional institutions and law enforcement regarding persons in lawful custody; and

You may be able to opt out of use or disclosure of your medical information pursuant to a written request from a government agency, unless the disclosure is required by law.

We may not disclose HIV test results, certain confidential medical information or mental health treatment records for certain of these purposes without your written permission, unless required by law. Your HIV test results, if any, may be disclosed as set forth in Wisconsin Statutes §252.15(5)(a). A listing of the persons or circumstances set forth in that statute is available on request.

Acknowledgement of Notice of Privacy Practices

Under federal privacy laws we are required to provide you with our Notice of Privacy Practices. This Notice provides information about how we may use and disclose your protected health information. You are not required to sign and return the attached acknowledgement. We are required to give you this Notice. If you would like to acknowledge receipt of this Notice, please sign below and return it to: Madison Human Resources Department, Suite 261, 215 Martin Luther King, Jr. Blvd., Madison, WI 53703. If you have any questions regarding this acknowledgement please contact the Privacy Officer listed above.

NOTICE ACKNOWLEDGEMENT

I have received the Privacy Practices Notice of the Madison Human Resources Department.

_____ _____

Signature Date

_____

Print Name

Individual Rights

Contact Information: If you have any questions about your rights under this privacy notice please contact the Privacy Officer. Specific contact information is located at the end of this notice.

Forms: You may obtain necessary forms to exercise your rights from the Privacy Officer. Specific contact information is located at the end of this notice

Access: You have the right to examine and to receive a copy of your medical information, with limited exceptions. You must make a written request to obtain access to your medical information.

We may charge you reasonable, cost-based fees for a copy of your medical information, for mailing the copy to you, and for preparing any summary or explanation of your medical information you request. Contact us using the information at the end of this notice for information about our fees.

Disclosure Accounting: You have the right to a list of instances in which we disclose your medical information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities as authorized by law.

Within 60 days of you request, we will provide you with information about each accountable disclosure that we made during the period for which you request the accounting, except we are not obligated to account for a disclosure that occurred more than 6 years before the date of your request.

Amendment: You have the right to request that we amend your medical information. Your request must be in writing, and it must explain why the information should be amended.

We may deny your request only for certain reasons. If we deny your request, we will provide you a written explanation. If we accept your request, we will make your amendment part of your medical information and use reasonable efforts to inform others of the amendment who we know may have and rely on the unamended information to your detriment, as well as persons you want to receive the amendment.

Restriction: You have the right to request that we restrict our use or disclosure of your medical information for treatment, payment or health care operations, or with family, friends or others you identify. We are not required to agree to your request. If we do agree, we will abide by our agreement, except in a medical emergency or as required or authorized by law. We must agree to restrict the disclosure if the disclosure is for purposes of carrying out payment or health care operations and is not otherwise required by law and the protected health information pertains solely to a health care service for which we have been paid in full by you or other person on behalf of you, other than the health plan.

Confidential Communication: You have the right to request that we communicate with you about your medical information in confidence by alternative means or to alternative locations that you specify. You must make your request in writing. You should submit your request to the contact at the end of this notice. You may obtain a form from that contact to make your request.

We will accommodate your request if it is reasonable, specifies the alternative means or location for confidential communication. We will not ask you to explain the reason for your request.

Electronic Notice: If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Contact the Privacy Officer, using the contact information listed at the end of this notice.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact the Privacy Officer using the information at the end of this notice.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information, in response to a request you made to amend, restrict the use or disclosure of, or communicate in confidence about your medical information, you may complain to us using the contact information at the end of this notice. You also may submit a written complaint to the Office for Civil Rights of the United States Department of Health and Human Services. You may contact the Office of Civil Rights' Hotline at 1-800-368-1019.

We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Information

Madison Human Resources Department
Privacy Officer
Madison Municipal Building Ste. 261
215 Martin Luther King Jr. Blvd.
Madison, WI 53703
(608) 266-4615

NOTICE ACKNOWLEDGEMENT (Not Obtained)

In the event the individual or individual's representative does not sign the Notice Acknowledgement on the reverse side of this form, staff must document why the individual did not sign it. Staff should document below the good faith effort to obtain this acknowledgement and indicate whether the individual refused or was unable to sign the acknowledgement:

_____

_____.

I attest that the above information is correct.

_____ _____
Employee Signature Date

_____ _____
Print Name Title