ILLINOIS BREAST AND CERVICAL CANCER PROGRAM ENROLLMENT PACKET

CHECKLIST

Please complete the attached enrollment papers to the best of your knowledge. ***Signing and dating*** of required forms will be necessary prior to our being able to schedule your appointments. Simply check them off as you complete them.

☐ **Eligibility Determination Form**
Complete, sign & date

☐ **Health Assessment** (Breast and Cervical Screening Questions)
Complete to the best of your knowledge

☐ **Cornerstone Consent Form**
Please read the entire form and then complete, sign & date. This gives IBCCP Personnel permission to enter the information you provided into our computer system. Only the IBCCP Personnel have access to this information. This allows the IBCCP Personnel to keep your breast and cervical cancer screenings up-to-date, on a yearly basis.

☐ **Client Participation Agreement & Release of Information**
Please read, sign & date

☐ **Authorization to Obtain Information**
Please read, sign and date

☐ **Joint Notice of Privacy Practices and Consent**
Please read, sign and date

Please include the following verification with your enrollment/re-enrollment packet.

☐ **Income** Verification (2 most recent paycheck stub or recent 1040 tax form)
☐ **Age** Verification (copy of your driver's license, ID card or birth certificate)
☐ **Medicaid Verification** (copy of your card)
☐ **Insurance Verification** (copy of the front and back of your card)

Illinois Breast and Cervical Cancer Program
Eligibility Determination Form

Shaded area is for IBCCP office use only

☐ New Client Registration Date: _____	☐ Established Client Annual Date: _____	☐ Navigation Only Date: _____	Cornerstone # _____

Name: _____

Previous Last Name: _____

Age: _____ Birth Date: _____/_____/_____

Address: _____

City: _____ State: _____

Zip Code: _____ County: _____

Home Phone: _____

Cell Phone: _____

Day Phone: _____

Medical/Insurance Coverage: *Check all that apply.*

☐ Medicare Part B – Not eligible for IBCCP
☐ Medicaid ID number _____
☐ I DO NOT have insurance
☐ I have Insurance – Name of Carrier: _____
☐ Are you covered under a parent or spouse insurance?
☐ No ☐ Yes

If yes, Insurer Name: _____

Does insurance pay for: Pap tests? ☐ No ☐ Yes
Mammograms? ☐ No ☐ Yes

Do you have a deductible that must be met before diagnostic procedures are covered? ☐ No ☐ Yes

Please provide a copy of the front and back of your insurance card.

Employment Status:
☐ Employed full-time (35+ hours weekly) (EFT)
☐ Employed part-time (EPT)
☐ Not in the labor force (NLF)
☐ Seasonal/Migrant Farm Worker (SMF)
☐ Self-employed (SE)
☐ Temporary Worker (TW)
☐ Unemployed (UNE)

Marital Status:
☐ Never Married (01)
☐ Married (02)
☐ Other: _____

Years of Education Completed:
☐ _____ (EO # of years)
☐ Unknown (E099)

Income determination:

Total income before taxes (if married - total combined income before taxes): $_____ (circle one) per month/year

Number of people under age 18, your spouse (if applicable), and yourself, who are supported by this income: _____

Office Use Only: Income status for number in household:
At or below 250% of federal poverty level: ☐ Above 250% of federal poverty level: ☐

Are you of Hispanic or Latino origin?
☐ Yes (01) ☐ No (00)

Preferred language for delivery of service:
☐ English (E)
☐ Spanish (S)
☐ Other (O): _____

What races do you consider yourself? Mark ALL that apply.
☐ White
☐ Black or African American
☐ Asian
  ☐ Chinese ☐ Indian ☐ Japanese
  ☐ Vietnamese ☐ Korean ☐ Filipino
  ☐ Other _____
☐ Native Hawaiian/Other Pacific Islanders
☐ American Indian/Alaskan Native

How did you hear about this program?
☐ Poster (PO) ☐ Newspaper (ME)
☐ Flier (FL) ☐ Radio (ME)
☐ Brochure (BR) ☐ Television (ME)
☐ Community Navigator (C) ☐ Website (Agency/State) (WB)
☐ Community Event (CE)
☐ Physician or Health Care Provider (P)
Who: _____ Phone #: _____
☐ Other (OTH), Specify: _____

Barriers:
☐ None ☐ Transportation ☐ Child/family Care ☐ Work schedule
☐ Understanding medical needs ☐ Special needs ☐ Financial
☐ Need Interpreter ☐ Travel Distance ☐ Making appointments
☐ Other: _____

Comments:
_____
_____

What is the best time to schedule your appointments?
(Please mark your choices.) **Preferred Healthcare Provider:** _____

Day of the week: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Time of day: ☐ Early morning ☐ Mid-morning ☐ Early afternoon ☐ Late afternoon

I certify that the information I have provided on this application form is the truth to the best of my knowledge.

Applicant's Signature _____ **Date** _____

IBCCP Health Assessment

Name: **Date:**

YES	NO	BREAST HEALTH QUESTIONS
☐	☐	1. Do you routinely check your breasts for changes?
☐	☐	2. Have you noticed a lump in your breasts?
☐	☐	3. If yes, which breast? Right___ Left____
☐	☐	4. Have you noticed any breast tenderness or pain?
☐	☐	5. If yes, did the breast tenderness or pain increase around the time of your menstrual period?
☐	☐	6. If you answered yes to question #4, which breast? Right _____ Left_____
☐	☐	7. Have you noticed any spontaneous discharge (not from stimulation or squeezing) from your nipples?
☐	☐	8. If yes, which breast? Right _____ Left_____
☐	☐	9. Have you noticed any other symptoms related to your breasts? If yes, explain: _____
☐	☐	10. Have you ever had a breast exam done by a doctor or nurse?
☐	☐	11. If yes, list provider/clinic where breast exam was done: _____
☐	☐	12. If yes, date of last exam (before this current visit): _____/_____
☐	☐	13. Have you ever had a mammogram?
☐	☐	14. If yes, list provider/clinic where mammogram was done: _____
☐	☐	15. If yes, date of your last mammogram (before this current visit):___/_____
☐	☐	16. If unknown was it more than 5 years?
☐	☐	17. Have you ever had breast cancer?
☐	☐	18. Has your mother, father, sibling (sister/brother), daughter or son had breast cancer? If no, go to question 22.
☐	☐	19. If yes to #18, who _____
☐	☐	20. Are they BRCA positive (if unknown leave blank)?
☐	☐	21. If yes to #18, at what age? _____ years old
☐	☐	22. Do you have a breast implant or implants?
☐	☐	23. Have you ever had a breast biopsy, breast cyst aspiration or surgery on your breast?
☐	☐	24. If yes, which breast? Right _____ Left_____
☐	☐	25. If yes, list the provider who performed the procedure_____
☐	☐	26. Have you ever had radiation to the chest area?

YES	NO	CERVICAL HEALTH QUESTIONS
☐	☐	27. Have you ever had a Pap test?
☐	☐	28. If yes, list provider where Pap test was done: _____
☐	☐	29. If yes, date of last Pap test: (before this current visit) ___/____
☐	☐	30. If date unknown, was it more than 10 years ago? Please guess and write the date in #29.
☐	☐	31. Were your last Pap test results normal?
☐	☐	32. What was the date of your last menstrual period? _____/_____/_____
☐	☐	33. Are you pregnant?
☐	☐	34. Have you had a hysterectomy?
☐	☐	35. If yes, was your cervix removed? I do not know_____
☐	☐	36. If you had a hysterectomy, was it due to a past history of cervical disease or cervical cancer?
☐	☐	37. Were you exposed to Diethylstilbestrol (DES)?
☐	☐	38. Is your immune system weakened in any way? (medication, HIV, organ transplant or other health condition)

YES	NO	TOBACCO QUESTIONS
☐	☐	39. Do you smoke cigarettes?
☐	☐	40. If yes, are you ready to quit smoking?
☐	☐	41. If yes, are you interested in being referred to the Illinois Tobacco Quitline?

(Shaded area for IBCCP office use)

42. What date was the referral sent to the Tobacco Quitline?
/ /

BARRIER/RISK ASSESSMENT QUESTIONS

Barrier Assessment

43. from Eligibility Determination form

Breast Cancer Risk Assessment

(from Summary Office Visit form)

44. Life time risk_____

45. High risk for breast cancer
- ☐ yes, client is high risk
- ☐ no, client is not high risk
- ☐ not assessed/unknown

Cervical Cancer Risk Assessment

46. High risk for cervical cancer
- ☐ yes, client is high risk
- ☐ no, client is not high risk
- ☐ not assessed/unknown

NIH-National Cancer Institute-Breast Cancer Risk Assessment Tool

Risk assessment tools can help health professionals estimate a woman's breast cancer risk. These tools give rough estimates of breast cancer risk, based on different combinations of risk factors and different data sets. A women's risk estimates can also change over time. The use of any of the risk assessment tools and its results should be discussed by a woman with her health care provider.

Please fill out this questionnaire and send back with your IBCCP paperwork.

1. Do you have a medical history of any breast cancer or ductal carcinoma in situ (DCIS) or lobular carcinoma in situ (LCIS) or have you received previous radiation therapy to the chest for treatment of Hodgkin Lymphoma?
   ___ YES
   ___ NO

2. Do you have a mutation in either the BRCA1 (Breast Cancer Gene) and BRCA2 gene?
   ___Yes
   ___ No
   ___Unknown

3. What is your age?
   _____ Years old

4. What is your race/ethnicity?
   ____ White
   ____ Black
   ____ Hispanic/Latina
   ____ Asian American
   ____ American Indian

   Place of birth?
   ____ Born in US
   ____ Born Outside of US

   Asian sub-type:
   ____ Chinese
   ____ Filipino

____ Hawaiian
____ Pacific Islander
____ Japanese
____ Other Asian

5. Have you ever had a breast biopsy with a benign (not cancer) diagnosis?
____ Yes
____ No
____ Unknown

6. How many breast biopsies with a benign diagnosis have you had?
____ None
____ One
____ Two or more

7. Have you ever had a breast biopsy with atypical hyperplasia?
____ Yes
____ No
____ Unknown

8. What was the age at the time of your first menstrual period?
____ 7 to 11
____ 12 to 13
____ 14 or older

9. What age were you when you gave birth to your first child?
____ No births
____ Under 20
____ 20-24
____ 25-29
____ 30 or older
____ Unknown

10. How many first-degree relatives (mother, sisters, daughters) have had breast cancer?
____ None ____ Unknown
____ One
____ More than one

ILLINOIS BREAST AND CERVICAL CANCER PROGRAM

CLIENT PARTICIPATION AGREEMENT AND RELEASE OF INFORMATION

I. PROGRAM DESCRIPTION:

The Illinois Breast and Cervical Cancer Program (program) is a cooperative effort between the Illinois Department of Public Health, Office of Women's Health and Family Services, and the U.S. Centers for Disease Control and Prevention (CDC). The program encourages routine breast and cervical cancer screening and provides free screening and some diagnostic examinations to eligible Illinois women. The purpose of routine breast and cervical screening is to detect cancer, if present, at an early stage so it can be treated or cured. Screening for breast cancer involves a clinical breast examination and a mammogram (a breast X-ray). Screening for cervical cancer involves a pelvic examination and a Pap test (scraping from the cervix).

II. CONSENT TO PARTICIPATE AND RELEASE OF INFORMATION:

I understand and agree to the following:

- I will provide proof of age and income to determine program eligibility. If I have insurance coverage, I will provide a copy of my insurance card and written verification of covered services. If while enrolled in IBCCP I obtain insurance, I will inform Lead Agency staff.

- I give permission to my health care provider(s), insurance company, hospital, clinic, laboratory and/or mammography facility to provide information concerning my breast and cervical cancer screening, diagnostic examinations and/or treatment status to program staff.

- I understand that the program must obtain certain statistical information for reports, including but not limited to age, income, insurance and any services I am provided through this program. This information may be used by the program and the CDC to learn more about breast and cervical cancer and to ensure the quality of services provided through the program. **My name will not be used in these reports, except as required by law.**

- My health care provider and/or the program staff will try to contact me regarding my test results. I understand that, despite efforts to find me, my health is my own responsibility and I may need to contact my provider for my test results.

- I understand that if the provider orders tests not covered by the program or my insurance that I may be responsible for payment of those IBCCP services as the program cannot pay for some diagnostic exams. A list of allowable services is available upon request.

- If I am diagnosed with a pre-cancerous or cancerous condition of my breasts or cervix, information from my IBCCP file will be released to the Illinois Department of Healthcare and Family Services. This information will be used to determine if I am eligible for state paid health benefits through Medicaid.

- If I am not eligible for Medicaid coverage, the program staff will assist with referral for treatment services through private sources, community based sources, other governmental grants or pro bono from a provider.

- If I am eligible for state paid health benefits through Medicaid, I give my permission for program staff to obtain information about my treatment for breast or cervical cancer. This information will be used to determine my treatment status and my continued enrollment in Medicaid.

- I will receive notification from the program staff to remind me when it is time for me to go back to my medical provider for my annual examination and follow-up testing, if appropriate (This does not apply to insured clients).

- I will notify the program of any change in my address and/or telephone number.

- I will write or call the local program staff to inform them if I no longer wish to be a part of this program. This notification will be recorded in my program records.

- I understand the importance of keeping all appointments made for me so my care can be provided in a timely manner. When it is necessary to cancel or change an appointment, I will notify the agency of this change.

- Missed appointments or repeated "no show" appointments are not acceptable and I can potentially lose my ability to receive IBCCP services if this happens.

III. ACKNOWLEDGMENTS:

- I have received literature and/or education on all of the following: breast health, mammograms, and Pap tests. _____
(initial here)

- The University of Illinois at Chicago (UIC), an IBCCP partner, conducts an annual survey for the purpose of helping the Department improve the quality of the program so that the Department can provide better services to program participants. UIC will be contacting you about this survey at a future date. We hope that you will participate, but your participation is completely voluntary, and your program eligibility will not be affected if you choose not to participate. Your initials here acknowledge that you have received notification of this voluntary survey. _____
(initial here)

Client Signature _____ **Date** _____

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
OFFICE OF WOMEN'S HEALTH AND FAMILY SERVICES
BREAST AND CERVICAL CANCER PROGRAM

AUTHORIZATION TO OBTAIN INFORMATION

I hereby give consent to release the following information:

- ☑ Clinic Report
- ☑ Medical Reports
- ☑ Laboratory Report
- ☑ Other _____

Regarding:
Client's Name: _____

Client's Address: _____

Date of Birth: _____/_____/_____

To: Agency Name & Address, ATTN: Illinois Breast & Cervical Cancer Program

LaSalle County Health Department
717 E. Etna Road
Ottawa, IL 61350 - 1097

Phone: 815 433 3366

I agree to release said provider, its employees, agents and representatives from any liability, loss, damage, costs, claims and/or cause of action connected with released information pursuant to this authorization.

I understand I have the right to revoke this consent at any time by giving written notice. Unless I revoke sooner, this consent will expire one (1) year from the date of signature.

I understand and agree that a photo static copy or facsimile of this consent will be valid as the original, even though such copy does not contain the original writing of my signature.

_____ _____
Signature Date

_____ _____
Witness Date

CONSENT and ACKNOWLEDGEMENT
Receipt of Joint Notice of Privacy Practices

I, _____ (print name of client) do hereby consent to allow
LCHD (agency name) and its designated employees
and contractors to perform:

- Pelvic and/or breast examinations and screenings and
- Necessary diagnostic follow-up tests

I understand the nature and consequences of any procedures to be performed will be explained to me.

I understand that the health department is already authorized to use the information gained during treatment to bill me, my insurance company, or any other potential sources of reimbursement, such as government programs in which I am enrolled or qualify for services.

I also hereby acknowledge that I received a copy of the "Joint Notice of Privacy Practices" from the agency dated August 21, 2013.

_____
Signed

_____
Date

FOR STAFF USE ONLY:
I attempted to obtain an Acknowledgement of the Receipt of the Notice of Privacy Practices on behalf of the delegate agency. The agency was unable to obtain the Acknowledgement because:

☐ Client refuses to sign
☐ Other _____ (specify)

_____ Staff member's initials _____ Date

(Staff: Place Acknowledgement in patient's medical record.)

ILLINOIS BREAST AND CERVICAL CANCER PROGRAM
NO-INCOME AFFIDAVIT

I, _____, hereby certify the following:
Print Name

Please check all that apply:

☐ I am over the age of 18 and currently am unable to remain in my residence. I will be admitted to hospice imminently.

☐ Prior to my cancer diagnosis, I earned approximately $_____/year.

☐ I currently do not earn, and do not expect to earn over the next twelve months, income from any employer; and I do not receive any supplemental income from any public or private sources; and

☐ I do not receive any ongoing payments from rents, royalties, recurring gifts, hobby income, insurance payments, disability or unemployment benefits, retirement income, investment income; etc.

This affidavit is made under penalty of perjury. Any fraudulent or untrue Statements made in this affidavit will result in denial of Health Benefits for Persons with Breast or Cervical Cancer and/or possible legal action.

Signature_____ Date: _____

Witness to Signature: _____ Date: _____

September 2013

LaSalle County Health Department

Notice of Privacy Practices

This Notice of Privacy Practices describes how medical information about you may be used and disclosed; and how you can get access to this information. Please review it carefully.

If you have questions about this Notice, please contact our office.

Who Will Follow This Notice

This "Notice of Privacy Practices" (aka Notice) describes the privacy practices of the LaSalle County Health Department (aka Department) and those of:

- Any health care professional authorized to enter information into your medical chart.
- All divisions and units of the Department, and the operations the Department outsources to certain of our business partners, as well as their Business Associates.
- All of our workforce, employed or otherwise.

All these entities, sites and locations follow the terms of this Notice. In addition, these entities, sites and locations may share medical information with each other for treatment, payment or operations purposes described in this Notice.

Our Pledge Regarding Medical Information

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at our facilities. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by us. Your hospital or other physicians may have different policies or notices regarding the use and disclosure of medical information they create.

This Notice will tell you about the ways in which we may use and disclose medical information about you. It also describes your rights, and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- Make sure that medical information that identifies you is kept private;
- Make available to you this Notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the Notice that is currently in effect. This Notice may change, in the manner described below under "Changes To This Notice."

The following categories describe different ways that we use and disclose your your medical information (also known as Individually Identifiable Health Information (IIHI) and/or Protected Health Information (PHI)). For each category of use or disclosure, we provide examples, but not every use or disclosure in a category is listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- **For Treatment**
  We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you. For example, we may forward your records to another specialist to assure that you receive proper care. Also, if you were referred to us by another health care provider, it is likely that we will report back to that provider with information about our diagnosis and plan for treatment.

  We may disclose medical information about you to people outside the Department who may be involved in your medical care, such as family members, close friends, clergy or others we use to provide services that are a part of your care. For instance, from time-to-time we may receive calls from concerned family members or close friends to determine if a patient has completed his or her appointment. Unless you have advised us otherwise, in writing, we will let them know your current status with our office. In addition, at some time, it may be necessary for our staff to reach you by telephone in regard to your appointment. Unless otherwise notified by you in writing, we will contact you using numbers you have provided and we may have to leave a voicemail message for you. In certain circumstances, care givers from nursing homes, assisted living centers, etc. will bring a patient to our facility. Often these care givers are exposed to that patient's personal health information.

- **For Payment**
  We may use and disclose medical information about you so that the treatment and services you receive from us may be billed to and collected from you, an insurance company or health plan or other third party. For example, we may need to give your health plan specific information about treatment you received at our office so your health plan will pay us or reimburse you for the treatment. In addition, we, or our representatives, may discuss payment issues with family members or others involved in the process of paying for medical treatment you have received. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. We may have our bills and payment arrangements outsourced to one or more third-party service providers who issue, process and collect bills on our behalf. Each of these is governed by the same health care information disclosure and confidentiality laws that we must follow.

- **For Health Care Operations**
  We may use and disclose medical information about you for our Department operations. These uses and disclosures are necessary to run our Department and make sure that all our patients receive quality care. For example, we may use medical information to review our treatment and services, and to evaluate the performance of our staff in caring for you. We may also combine medical information about many of our patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technologists, medical students, and other members of our staff for review and learning purposes.

- **Treatment Alternatives**
  We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

- **Business Associates**
  On occasion the Department may use outside organizations to provide business services. Business Associates that will be exposed to your health information are required to comply with

all the same HIPAA administrative, physical and technical safeguard requirements that apply to the Department. Also, if the business associate contracts with a third party, they too must comply with all HIPAA rules.

- **As Required By Law**
  We will disclose medical information about you when required to do so by federal, state or local law.

- **To Avert A Serious Threat To Health Or Safety**
  We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety, or the health and safety of the public, or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

- **Special Situations**
  We may also use and disclose medical information about you in the situations described under "Special Situations," below.

Other Uses Of Medical Information

Other uses and disclosures of medical information not covered by this Notice, or the laws that apply to us, will be made only with your written authorization. A form for such authorizations, both those that you request and those that we request, is available from our office. If you give us an authorization, you may later revoke that permission in writing at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. In that case, however, we will be unable to take back any disclosures we have already made with your permission, and we will still be required to retain our records of the care that we provided to you.

Special Situations *(Including but not limited to...)*

Military and Veterans

If you are a member of the armed forces, we may release medical information about you as required by military command authorities, or in some cases, if needed to determine benefits to the Department of Veterans Affairs.

Public Health Risks

We may disclose medical information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability;
- To report births and deaths;
- To report child abuse or neglect;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and/or
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure when required or authorized by law.

Health Oversight Activities

We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Immunization Reporting

The Department may disclose proof of immunization to a school where law requires a school to have such information. Written authorization for this disclosure is not required, however, the Department will obtain agreement to this release, which may be oral, from a parent, guardian or other person acting in *loco parentis* for the individual, or from the individual himself or herself, if the individual is an adult or emancipated minor.

Outside Use

It is a violation of Department Policy to use patient PHI for Marketing, Research or to sell PHI in any way. Under no circumstances will the Department engage in these activities.

Fundraising

It is a violation of Department Policy to use patient PHI for fundraising purposes. The Department will not contact patients to conduct fundraising activities using PHI as a source of identification.

Lawsuits and Disputes

If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement

We may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at our practice; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors

We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

Decedents

A decedent's PHI is protected for 50 years after the individual's death. After that point, the information is no longer considered PHI.

National Security, Intelligence and Federal Protective Service Activities

We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law, and to authorized federal officials where required to provide protection to the President of the United States, other authorized persons or foreign heads of state or conduct special investigations.

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 where necessary for the institution to provide you with health care; to protect your health and safety or the health and safety of others; or for the safety and security of the correctional institution.

Your Rights Regarding Medical Information About You

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

- **Right to Inspect and Copy**

  You have the right to inspect and request a copy of medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes.

  You may request an electronic copy of your PHI that is maintained electronically. The Department will provide an electronic copy in the form requested, if readily producible, or if not, in a readable electronic form and format as agreed by you and the Department

  You must submit any request to inspect and copy your medical records to our staff, in writing. (A form for that request is available from our office.) If you request a copy of your information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

  We may deny your request in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another health care professional chosen by our staff will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of that review.

- **Right to Amend**

  If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our Department. You must submit any request for an amendment to our staff, in writing. (A form for that request is available from our office.) Your written request must provide a reason that supports your request.

  We may deny your request for an amendment if it is not in writing, or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

  - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
  - Is not part of the medical information kept by or for our Department.
  - Is not part of the information which you are permitted to inspect and copy; or
  - Is accurate and complete.

- **Right to an Accounting of Disclosures**

  You have the right to request an "accounting of disclosures." This is a list of the disclosures we have made of medical information about you, with some exceptions. The exceptions are governed by federal health privacy law, and may include:

  - Many routine disclosures for treatment, payment and operations; and
  - Disclosures to you.

  You must submit any request for an accounting of disclosures to our office, in writing. (A form for that request is available from our office.) Your written request must state a time period, which may not be longer than six years. The first report you request within a 12-month period will be free. For additional reports, we may charge you for the costs of providing the report. We will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions**

  You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right

to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a medical service you received. Also, you have the right to designate a personal representative who will then have the ability to access your personal health information, just as you do. You may also ask us to be selective in the way we communicate personal health information to you. For example, you may request that we not contact you by telephone at your office or you may designate a mailing address other than your home. Such requests must be made in writing. (A form for such requests is available from our office.) Please note that we are not required to agree to your requests. However, if we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

You have the right to restrict the disclosure of PHI (for payment or health care operations) to a health plan when you pay out-of-pocket, in full, and request such a restriction. The Department must honor such a request unless otherwise required by law. This restriction does not apply to follow-up visits if they are not paid for in full out of pocket.

You must submit any request for restrictions to our staff, in writing. (A form for each request is available from our office.) Your written request must tell us:

- What information you want to limit;
- Whether you want to limit our use, disclosure or both; and
- To whom you want the limits to apply, for example, disclosures to your spouse.

- **Right to a Paper Copy of This Notice**
  You may ask us to give you a paper copy of this "Notice of Privacy Practices" at any time by contacting our office.

- **Right to Receive a Breach Notice**
  Should the Department experience an impermissible use or disclosure of PHI and that exposure poses a significant risk of financial, reputational, or other harm to an individual, the Department will provide individual notice to all persons affected by the breach.

- **Complaints**
  If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact our office. (A form for this purpose is available from our office.) You will not be penalized for filing a complaint.

The Department's Right to Make Changes to This Notice

The Department reserves the right to change this Notice. When we do, we may make the changed Notice effective for medical information we already have about you, as well as information we receive in the future. We will post a copy of the current Notice in our facilities. Each Notice will contain on the first page, in the top right-hand corner, its effective date. Also, each time you register at our office for medical services, a copy of the current Notice in effect will be available to you in the waiting area.

LaSalle County Health Department

Acknowledgment of Notice of Privacy Practices

My signature below indicates that I have been given an opportunity to read the Notice Of Privacy Practices for the LaSalle County Health Department, and to have any questions answered before signing.

Signed: _____ Date: _____

Print Name: _____

If signed by someone other than the patient, please indicate relationship to patient:

[ ] Parent or guardian of minor patient

[ ] Guardian or conservator of an incompetent patient

[ ] Beneficiary or personal representative of deceased patient

FOR OFFICE USE ONLY:

Employee Signature: _____ Date_____

If patient or patient's representative refuses to sign this Acknowledgment:

[ ] Efforts to Obtain: _____

[ ] Reason patient refused to sign: _____