## WHITESIDE COUNTY HEALTH DEPARTMENT & COMMUNITY HEALTH CLINIC
## SUMMARY OF NOTICE OF PRIVACY PRACTICES & ACKNOWLEDGEMENT

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
***PLEASE REVIEW IT CAREFULLY***.

**YOUR RIGHTS**

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| **You have the right to:** | • Get a copy of your health and claims record<br>• Correct your health &claims record<br>• Request confidential communication<br>• Ask us to limit the information we share<br>• Get a list of those with whom we've shared your information<br>• Get a copy of this privacy notice<br>• Choose someone to act for you as your personal representative<br>• File a complaint if you believe your privacy rights have been violated |

**YOUR CHOICES**

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| **You have some choices in the way that we may share your information:** | • Disclosing information to your family and friends (requires written authorization)<br>• Tell family and friends about your condition<br>• Provide disaster relief<br>• Market our services and sell your information (requires written authorization)<br>• Raise funds<br>• Disclosing return to work notes to your employer<br>• Disclosing return to school notes to your school |

**OUR USES AND DISCLOSURES**

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| **We may use & share your information as we:** | • Treat you<br>• Run our organization<br>• Bill for your health services<br>• Help with public health and safety issues such as governmentally declared public health emergencies<br>• Do research<br>• Comply with the law, such as providing proof of immunity to a school<br>• Respond to organ & tissue donation requests and work with a medical examiner or funeral director<br>• Address workers' compensation, law enforcement, and other government requests<br>• Respond to lawsuits and legal actions<br>• Provide you with appointment reminders such as voicemail messages, postcards, texts or letters |

*We will, under most circumstances, not share any health information regarding Behavioral or Mental Health Services, Substance Abuse(drug/alcohol) Treatment, Physical Assault/Abuse/Neglect, and/or Sexually Transmitted Diseases including HIV/AIDS u*nless specifically requested by a fully executed Authorization to Release Health Care Information.

**OUR RESPONSIBILITIES**

We are required by law to maintain the privacy and security of your protected health information.
We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
We must follow the duties and privacy practices described in this notice and give you a copy of it.
We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

**CHANGES TO THE TERMS OF THIS NOTICE**

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

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| ***I acknowledge that I have been given an opportunity to read this notice and receipt of the notice. I know that I may ask for a copy of the full notice.***<br><br>***I authorize Whiteside County Health Department/CHC to release school physical records, dental records, to my child's School.*** | Authorization to Release Health Care Information<br><br>_____<br>Patient (*or Parent/Guardian*) Signature Date |