

**Yale University Health Services**  
**17 Hillhouse Avenue**  
**P.O. Box 208237**  
**New Haven, CT 06520-8237**

May 2008

Dear YUHS Patient:

As many of you know, a discussion about how best to protect medical privacy has been underway since the passage by Congress in 1996 of the Health Insurance Portability and Accountability Act (HIPAA). The six-year public debate about how to implement HIPAA's provisions allowed time for health care entities, including Yale Health Plan, to develop privacy policies which reflect the needs of their particular populations within HIPAA guidelines.

HIPAA requires the adoption by medical facilities of security and privacy standards to protect personal health information. The rule limits the use and release of individually identifiable health information; gives patients the right to access their medical records; restricts most disclosures of health information to the minimum needed for the intended purpose; and establishes safeguards regarding disclosure of records for certain public responsibilities, such as public health and law enforcement.

As part of compliance with HIPAA, we are providing this notice describing how medical information about you may be used and disclosed and how you can obtain this information. Please review it carefully and sign and return the acknowledgement statement by June 30, 2008 (parents or guardians sign for minor children). If you need more information, call the Member Services Department at 203.432.0246. Thank you for your cooperation.

Sincerely,

A handwritten signature in cursive script that reads "Paul Genecin". The signature is written in black ink and is positioned to the left of a vertical red line.

Paul Genecin, M.D.  
Director

# Notice of Privacy Practices

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**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. IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT OUR PRIVACY OFFICE IN WRITING OR CALL MEMBER SERVICES AT 203-432-0246.**

## **WHO HAS TO ABIDE BY THESE PRIVACY PRACTICES**

Yale University Health Services (YUHS) provides health care to our patients in partnership with other professionals and organizations. The following individuals will abide by the privacy practices in this notice:

- Any health care professional who treats you at YUHS.
- All members of the YUHS work force, including employees, medical staff, trainees, students, and volunteers.

## **OUR PLEDGE TO YOU**

We understand that medical information about you is personal and we are committed to protecting that information. Your medical record is created as part of providing you with quality care, as well as for the purpose of meeting legal requirements. This notice applies to all the records of your care generated or maintained by YUHS. 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; and
- Follow the terms of the privacy practice notice that is currently in effect.

## **HOW WE MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION**

We may use and disclose medical information about you without your prior authorization for **treatment**, such as sending medical information about you to a specialist as part of a referral (this includes psychiatric or HIV information if needed for purposes of your diagnosis and treatment); **to obtain payment for treatment**, such as sending billing information to your insurance company or Medicare - (note: only limited psychiatric or HIV information may be disclosed without your authorization for billing purposes); and **to support our health care operations** (such as comparing patient data to improve treatment methods).

Other examples of such uses and disclosures include: contacting you for **appointment reminders**, or to inform you about **possible treatment options and health-related benefits or services** that may be of interest to you.

- We may use or disclose medical information about you without your prior authorization for several other reasons. Subject to certain requirements, we may communicate medical information about you, without your prior authorization, for the following: public health purposes; abuse or neglect reporting; health oversight audits or inspections; to fulfill a request from a medical examiner; funeral arrangements and organ donations; workers' compensation claims; emergencies; national security needs and other specialized government functions; and for members of the Armed Forces as required by Military Command authorities. We also disclose medical information when required by law, such as in response to a request from law enforcement in specific circumstances, or in response to valid judicial or administrative orders.
- The Inpatient Care Facility (ICF) has procedures which protect patient privacy while allowing for information to be given to those whom the patient designates. Patients are informed of these procedures upon their admission to the ICF.
- We may use or disclose information about you without your authorization as part of a "limited data set" which includes limited information (such as your city or a visit date, but not your name or address), but only for certain health care operations, public health and research purposes. The recipient of the information must sign a promise to restrict how the limited data set is used.
- Under certain circumstances, we may use and disclose health information about you for research purposes, subject to an approval process. We may also allow potential researchers to review information that may help them prepare for research, so long as the information they review does not leave our facility and they agree to specific privacy protections.
- We may disclose medical information about you to a friend or family member whom you designate. We may also disclose medical information to a friend or family member if a practitioner determines it is appropriate under the circumstances, unless you inform us otherwise. We may also disclose information to disaster relief authorities so that your family can be notified of your location and condition.

## OTHER USES OF MEDICAL INFORMATION

- In any other situation not covered by this notice, we will ask for your written authorization before using or disclosing medical information about you. If you choose to authorize use or disclosure, you can later revoke that authorization by writing to:

Manager of Medical Records / Yale University Health Services /  
17 Hillhouse Avenue / Box 208237 / New Haven, CT 06520-8237

## YOUR RIGHTS REGARDING YOUR MEDICAL RECORD

- In most cases, **you have the right to look at or get a copy of medical information** that we use to make decisions about your care. To do so, you must submit a written request to the address below. We may charge a fee for the cost of copying, mailing, or related supplies. If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision to:

Manager of Medical Records / Yale University Health Services /  
17 Hillhouse Avenue / Box 208237 / New Haven, CT 06520-8237

- If you believe that information in your record is incorrect or incomplete, **you have the right to request that we correct the records**. Please send a written request to the address below, providing your reason for requesting the amendment. We may deny your request 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 your record is accurate; or under certain other circumstances. You may submit a written statement of disagreement with a decision by us not to amend a record to:

Manager of Medical Records / Yale University Health Services /  
17 Hillhouse Avenue / Box 208237 / New Haven, CT 06520-8237

## YOU HAVE THE RIGHT TO KNOW WHEN YOUR MEDICAL INFORMATION HAS BEEN RELEASED

- You have the right to request a list of disclosures we have made of your health information. The list will not include: (1) disclosures made for treatment, payment, and health care operations, as previously described; or (2) disclosures made in circumstances where you have given specific and separate authorization or (3) certain other disclosures in accordance with the law.
- Please note that this policy will be in effect beginning April 14, 2003. You must indicate the time period for which you request the list of disclosures, which can be up to six years prior to the date of your request. Disclosure lists will be kept for a rolling period of six years. Requests can be made for any time within that six year period and must be submitted in writing to:

Manager of Medical Records / Yale University Health Services /  
17 Hillhouse Avenue / Box 208237 / New Haven, CT 06520-8237

## YOU HAVE THE RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS

**You have the right to request that medical information about you be communicated to you in a confidential manner**, such as sending mail to an address other than your home. You may notify us of how you would like us to communicate with you by writing to:

Member Services Department / Yale University Health Services /  
17 Hillhouse Avenue / Box 208237 / New Haven, CT 06520-8237

## YOU HAVE THE RIGHT TO REQUEST RESTRICTIONS ON THE USE OF YOUR MEDICAL INFORMATION

**You may make a written request to restrict our use or disclosure of medical information about you.** You may make the following request: that we not use or disclose information for treatment, payment or health care operations or to persons involved in your care except when (1) specifically authorized by you; (2) when we are required by law to disclose the information; or (3) in an emergency. We will consider your request but we are not legally required to accept it. We will inform you of our decision. All written requests or appeals should be submitted to:

Deputy Privacy Officer / Yale University Health Services /  
17 Hillhouse Avenue / Box 208237 / New Haven, CT 06520-8237

## YOU HAVE THE RIGHT TO REQUEST A PAPER COPY OF THIS NOTICE

You may receive a paper copy of this notice upon request even if you have previously agreed to receive this notice electronically.

## IF WE CHANGE OUR POLICIES

If we change our policies, the changes will apply to medical information we already hold, as well as new information generated after the change occurs. Before we make a significant change in our policies, we will post the notice of the new policies in prominent areas and on our web site at [www.yale.edu/uhs](http://www.yale.edu/uhs). You can receive a copy of the current policy at any time even if you have previously agreed to receive this notice electronically. Copies of the current notice will be available at all times at the facility. The effective date is printed at the end of the notice.

## TO REGISTER A COMPLAINT

- 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 Office by writing to:  
Deputy Privacy Officer / Yale University Health Services /  
17 Hillhouse Avenue / Box 208237 / New Haven, CT 06520-8237
- You may send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights. Our Privacy Office can provide you the address.
- You will not experience penalties or retaliation for filing a complaint.

**This notice is effective as of 04/14/03**

# Yale University Health Services

17 Hillhouse Avenue  
P.O. Box 208237  
New Haven, CT 06520-8237  
Member Services - 203-432-0246

MRN: \_\_\_\_\_

for office use only

## Acknowledgement of receipt of Notice of Privacy Practices

Each adult Yale University Health Services (YUHS) patient must return a completed form indicating that they have received YUHS's Notice of Privacy Practices. In addition, a form must be signed by a parent or guardian for each child under the age of 18 who is also a patient or incapacitated adult patients.

Printed name  
of YUHS patient: \_\_\_\_\_

Patient's date of birth: \_\_\_\_\_ month / day / year  
Patient's telephone number: \_\_\_\_\_ home  
\_\_\_\_\_ work  
\_\_\_\_\_ cell

Patient's signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Or for child under 18 or incapacitated adult patients:

Signature of parent or guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Patient's address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

For office use only	Initials:	Date Processed:	