

USM SPEECH-LANGUAGE-AUDIOLOGY CLINIC NOTICE OF PRIVACY PRACTICES

Effective Date: September 8, 2004

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THE INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR PRIVACY RIGHTS, OUR RESPONSIBILITIES

The USM Speech-Language-Audiology Clinic is required by law to protect the privacy of your health information and provide you with this Notice of Privacy Practices. This Notice describes how we may use and share your health information and explains your privacy rights. The Clinic will use or disclose your information only as described in this Notice. We do, however, reserve the right to change our privacy practices and the terms of this Notice and to make new provisions effective for all health information that we maintain. If this notice is revised at any time while you are receiving services at our Clinic, you will be provided a copy of the revised notice.

If at any time, you have questions or concerns about the information in this Notice or about our agency's privacy policies, procedures, or practices; you may contact the HIPAA Coordinator (see Contact Information on the reverse page).

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION WITHOUT AUTHORIZATION

The law permits the U.S.M. Speech-Language-Audiology Clinic to use or disclose your health information without your written consent or authorization for the following purposes:

Treatment: We may use health information about you to provide treatment and services. This may include disclosing your health information to clinicians, supervisors, or administrators of the USM Speech-Language-Audiology Clinic who are involved in your treatment. Because our clinicians are graduate students in training, they are required to share information pertaining to your treatment with their clinical supervisor. In addition, clinicians may share relevant details about your treatment during case staffing with other clinical supervisors and/or clinicians working in the Clinic. Similarly, your health information may be shared with faculty supervisors providing emergency backup coverage to the Clinic.

Clinic Operations: We may use your health information for the purposes of Clinic operations. For example, your records will be reviewed by the Clinic Director in order to make sure that the Clinic is the best place for you to receive treatment. In addition, your records may be reviewed by the Clinic Coordinator to assess the quality of services you receive and to ensure that your record is properly maintained.

Contacting you: We may contact you to remind you of an appointment, reschedule a missed appointment, provide information about new services that may be of interest to you, or assess satisfaction with ongoing treatment.

Other Circumstances: In addition, we may use or disclose your health information for the following purposes *without* your consent or authorization:

- As required or permitted by law (e.g., cooperation with law enforcement, court officials, or government agencies)
- For health oversight activities (e.g., investigations, inspections, accreditation, licensure, etc.)
- To avoid serious threat to health or safety.
- As authorized by worker's compensation laws or similar programs that provide benefits for work-related injuries or illness.

- Research approved by the University of Southern Mississippi's Human Subjects Protection Review committee (in such cases, personally identifiable information will never be reported).

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION THAT REQUIRES YOUR AUTHORIZATION

Except as provided in this Notice of Privacy Practices, the USM Speech-Language-Audiology Clinic will not use or disclose your health information without your written authorization. If you sign an authorization form, you may withdraw your authorization at any time, as long as your withdrawal is in writing.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have several rights with regard to your health information. Specifically, you have the right to:

- **Obtain a paper copy of this Notice.** You may request a written copy of this Notice at any time.
- **Request confidential communications.** You have the right to request in writing that the Clinic only communicate to you in a certain format (e.g., in writing) and/or location (e.g., your work address). We will accommodate all reasonable requests.
- **Inspect and copy records.** You have the right to request in writing to see your records and obtain a copy within 30 days at a reasonable fee. This right is subject to certain legal restrictions. For example, this right does not apply to clinical notes or information compiled for judicial proceedings. **if this request is denied you will be notified in writing of the reason for denial and your right to request review of the denial.*
- **Request restrictions on certain uses and disclosures.** You have the right to ask for restrictions on how your health information is used or to whom your information is disclosed. We are not required to agree to your requested restriction, but we will consider your request and the possibility of accommodating it.

Revised: 9/8/2004/MFC/RA

C:\Speech and Hearing\Clinic Forms\HIPAA Disclosure 1

- **Request to amendment.** You have the right to request in writing that portions of your records be corrected when you feel information is incorrect or incomplete. All such requests will be reviewed by the HIPAA Coordinator (Dr. Margaret Carlin). We may deny your request if the information was not created by this agency or if we believe the information is accurate.
- **Receive an accounting of disclosures.** You have a right to receive an accounting of disclosures of your health information that have been made by the Clinic, except for disclosures for the purpose of treatment, payment, clinic operations (described previously), and certain other disclosures as provided for by law.
- **Complain.** If you believe your health information privacy rights have been violated, you may contact the OCR Regional Manager, Office for Civil Rights, U.S. Department of Health and Human Services, Atlanta Federal Center, Suite 3B70, 61 Forsyth Street, S.W., Atlanta GA 30303-8909, (404) 562-7886. You may also request a privacy complaint form from the HIPAA Coordinator or your clinician. If you file a complaint, we will not take any action against you or change our treatment of you.

CONTACT FOR FUTHER INFORMATION

Ms. Lynn Boardman, M.S., CCC-SLP
 HIPAA Coordinator
 University of Southern Mississippi
 Speech and Hearing Sciences
 118 College Drive # 5092
 Hattiesburg MS 39406-0001
 (601) 266-5583

**UNIVERSITY OF SOUTHERN MISSISSIPPI
SPEECH-LANGUAGE-AUDIOLOGY CLINIC**

**118 COLLEGE DRIVE # 5092
HATTIESBURG, MS 39406-0001
PHONE (601)-266-5216**

AUTHORITY TO RELEASE/OBTAIN PROTECTED HEALTH INFORMATION

I, _____ hereby authorize The USM Speech-Language-Audiology Clinic to
release/obtain my protected health information/records to/from: _____
(circle one or both) (circle one or both)

(Name of Person & Title or Entity and Address to whom/from information will be disclosed/obtained)

I specifically authorize the release of health information and/or records pertaining to the following
(Must indicate by initialing and/or describing the amount and type of health information to be obtained/released):

<input type="checkbox"/> Diagnostics Evaluation and Assessment	<input type="checkbox"/> Educational Assessment
<input type="checkbox"/> Treatment Plans and Related Revisions	<input type="checkbox"/> Attendance Record
<input type="checkbox"/> Discharge/Termination Summary	
<input type="checkbox"/> Summary of Contacts	

Other (Describe other information/records to be disclosed _____)

My authorization of the release of this information and/or records is for the specific purpose of

(Describe purpose of the information to be disclosed)

Dates of service for which the information/record is requested or will be released: From: _____ To: _____

I understand that this authorization will be effective on the date signed and will expire on _____
(not to exceed 12 months) and cannot be renewed without my written authorization.

I understand that I have the right to revoke this authorization at any time. I understand that to revoke this authorization, I must provide a specific request to revoke the authorization in writing to the HIPAA Coordinator, Mr. Raymond Alexander, at the USM Speech-Language-Audiology Clinic.

I understand that my revocation will not apply to any information that has already been released/obtained in response to this authorization.

I understand that my authorizing the disclosure/obtaining of this health information is voluntary. I understand that I do not have to sign this form in order to receive treatment. I understand that I may inspect or copy information to be used or disclosed as provided for by law. I understand that any disclosure of my health information carries with the potential for a redisclosure and that the information may no longer be protected by federal confidentiality laws.

Initials _____