HIPAA NOTICE OF PRIVACY PRACTICES

Effective 1/1/14

Stanley Total Living Center, Inc.
514 Old Mount Holly Road
Stanley, NC 28164
(704) 263-1986
www.stanleytotallivingcenter.org

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.

This Notice of Privacy Practices describes how we, our Business Associates, and their subcontractors, may use and disclose your protected health information (PHI) to carry out necessary treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law (all of our Business Associates are obligated, by law and under contract with us, to protect the privacy of your protected health information). We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices, and to notify affected individuals following a breach of unsecured protected health information. This Notice also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future medical condition. **If you have any questions about this Notice, please contact our Privacy Officer (Director of Human Resources).**

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by us and others outside of our facility that are involved in your care and treatment for the purposes of providing health care services to you, to pay your health care bills, to support business operations, and any other use required by federal, state, and/or local law.

For treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care to a third party to communicate with other health care providers regarding your treatment, and coordinating and managing your health care with others.

Payment: We will use and disclose protected health information so that the services you receive from us may be billed for and payment may be collected from you or on your behalf from an insurance company or third party.

Healthcare Operations: We may use or disclose your protected health information in order to facilitate business operations which allow us to administer the benefits you are entitled to under your health plan. These activities include, but are not limited to, quality assessment and improvement, employee review, training of students, licensing, fundraising, and conducting or arranging for other business activities.

Required by Law: We will use and disclose your medical information whenever we are required by the law to do so. Examples of this include:

- Necessary to prevent or lessen a serious threat to health or safety
- Public health activities such as investigations of communicable disease, abuse/neglect reporting, or monitoring drugs and devices regulated by the FDA
- If you are an adult and we believe you are a victim of abuse, neglect, or domestic violence
- Court proceedings in response to a court order or a subpoena
- Use by law enforcement
- Use by a coroner, medical examiner, or funeral director or to organizations that help with organ transplants
- Certain government functions including military and veteran's activities and national security and intelligence agencies

Persons involved in your care: We may disclose your medical information to a relative, close personal friend, or any other person you identify if that person is involved in your care and the information is relevant to your care. We may also use or disclose your medical information to a relative, another person involved in your care, or possibly a disaster relief organization (such as the Red Cross) if an emergency and we need to notify someone of your location and/or health condition. You may ask at any time not to disclose your medical information to persons involved in your care. We will agree to your request and will not disclose such information except in certain circumstances such as emergency situations.

Authorizations: Other than the uses and disclosures described above, we will not use or disclose your medical information without your or your personal representative's authorization (signed permission). In some instances, we may wish to disclose or use your medical information and we may contact you to ask that you sign an authorization form. In other instances, you may contact us to disclose such information and we will ask you to sign the authorization form at that time.

If you sign a written authorization asking us to disclose your medical information to a third party, you may later revoke (or cancel) this authorization. If you would like to revoke this authorization, you must do so in writing. If you revoke the authorization, we will follow your instructions except to the extent that we have already relied upon your previous authorization to disclose your medical information or as required by law.

Other uses or disclosures requiring your preauthorization: We may only use or disclose your medical information for marketing purposes if we have your explicit approval and authorization. We may only disclose any psychotherapy notes with prior authorization from you or as required by law.

YOU HAVE RIGHTS WITH RESPECT TO YOUR MEDICAL INFORMATION

You have certain rights with respect to your medical information:

Right to choose someone to act for you: if you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your medical information. We verify that this person does in fact have this authority and can act on your behalf before we take any action.

Right to access to inspect and copy: you have the right to inspect (see or review) and receive a copy or summary of your medical information that Stanley Total Living Center maintains. If we maintain your records electronically, you may obtain an electronic copy. You may also instruct us in writing to send an electronic copy of your medical records to a third party. If you would like to inspect or to receive a copy of your medical information, you must provide us with a request in writing. We may deny your request under certain circumstances—if your request is denied, we will explain the reason in writing. Copies of your medical information will be charged to cover fees for the costs of the copies—these fees will be no more than the standard copying rates in our area.

Right to have medical information amended: If you believe that we have information that is either inaccurate or incomplete, you have the right to request an amendment, correction, or supplementation of your medical information that Stanley Total Living Center maintains. Your request must be in writing and include an explanation. We may deny your request to amend, correct, or supplement your medical information in certain circumstances. If we deny your request, we will explain our reason for doing so in writing within (60) days. You may send us a statement of disagreement. With any future disclosures, we will provide you with an accurate summary of the request and our denial.

Right to accounting of disclosures we have made: You have the right to receive an accounting (which means a detailed listing) of disclosure other than for treatment, payment, and health care operations we have made for the previous (6) years. If the information is contained in an electronic health record, the accounting if for the previous (3) years. We will provide one accounting each year for free but may charge a reasonable, cost-based fee should you ask for another one within 12 months.

Right to request restrictions on uses and disclosures: You have the right to request that we limit the use and disclosure of your medical information for treatment, payment, and health care operations, but Stanley Total Living Center may not agree to the restriction. Under federal law, Stanley Total Living Center must agree to your request to restrict disclosures of your

medical information if the disclosures are for the purposes of payment or health care operation and are not otherwise required by law and the medical information pertains solely to health care items or services for which you, or another person on your behalf (other than Stanley Total Living Center), has paid in full.

If we agree to your request, we must follow your restrictions, except if the information is necessary for emergency treatment. You may cancel the restriction at any time by writing to us. In addition, we may cancel a restriction at any time as long as we notify you of the cancellation, and continue to apply the restriction to information collected before the cancellation.

YOU MAY FILE A COMPLAINT ABOUT OUR PRIVACY PRACTICES

If you believe your privacy rights have been violated, you may file a written complaint either with Stanley Total Living Center or with the federal government.

Stanley Total Living Center will not take any action against you or change the treatment of you in any way if you file a complaint.

To file a written complaint with or request more information from Stanley Total Living Center, contact:

Stanley Total Living Center, Inc.
Attention: HIPAA Privacy Officer
514 Old Mount Holly Road
Stanley, NC 28164
(704) 263-1986

To file a written complaint with the federal government, please use the following information:

U.S. Department of Health and Human Services
Office for Civil Rights
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201
Tollfree (800) 368-1019

HIPAA NOTICE OF PRIVACY PRACTICES

I have read and understand the policies and procedures related to HIPAA including how medical information can be used/disclosed and how I can gain access to this information (or the information of the resident).

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Initials

I have read and understand my rights regarding HIPAA with respect to my medical information (or the information of the resident).

_____
Initials

I have read and understand how to file a complaint regarding privacy practices as they related to HIPAA regulations.

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Initials

_____ _____
SIGNATURE OF RESIDENT/RESPONSIBLE PARTY DATE