Trinity Washington University
Health and Wellness Center
125 Michigan Ave N.E.
Washington, DC 20017
202-884-9615

HIPAA Notice of Privacy Practices

This notice describes how medical/health information about you may be used/disclosed and how you can get access to this information. Please read it carefully, sign on the last page, and return to the Health and Wellness Center.

Your record is YOUR Health Information

Each time you visit The Health and Wellness Center, a record of your visit is made. It contains your medical history, symptoms, results of testing and examinations, lists of medication, and plan of care. Your health information contains personal information and there are state and federal laws to protect the privacy of your health information.

Use and Disclosure of Information

Treatment: All staff involved in your care will document in your record and have access to the information it contains. We may forward information to other providers involved in your care.

Training: Periodically, health studies students participate in a clinical capacity at The Health and Wellness Center. These students have signed confidentiality agreements prior to having any access to a medical record.

Payment: A bill will be sent to our insurance carrier for some services received at the Health and Wellness Center. The information accompanying the bill may include information that identifies your diagnoses, treatments, and supplies used. We may also contact your insurance company to confirm coverage.

Healthcare Operations: The Health and Wellness Center is subject to quality review by insurance and other entities and may review medical records in the course of such reviews.

Other Disclosures

Business Associates: Some of our services, such as laboratory work are provided through other business entities. To protect your health information, we require business associates to protect the information as well.

Communication with others: Health Professionals may disclose information to persons or family members ONLY IF you have consented in writing. We may communicate with insurers regarding payment for your care.

Research: Occasionally, health related information may be used for research purposes. All research projects are subject to special approval.

As required by Law

Health information may be disclosed to the following types of entities:

- Food and Drug Administration
- Public Health or authorities charged with disease prevention
- Correctional Institutions
- Workers Compensation Agents
- Organ and Tissue Donation Organizations

- Military Command Authorities
- Health Oversight Agencies
- Funeral Directors, Medical Examiners
- National Security and Intelligence Agencies
- Law enforcement as required by law or in accordance with a valid subpoena
- To avoid serious threat to the health and safety of a person or the public.

Patients' Rights

- Request a restriction on certain uses and disclosures of your information; we are not required to agree with you request. Even if we do agree with your restriction, some emergency situations may require release of information.
- Obtain a paper copy of this notice of privacy practices.
- Inspect and obtain a copy of your health record.
- Request communication of your health information in a certain way or certain location.
- Revoke your authorization to use or disclose health information, except to the extent that action has already been taken.
- To register complaints regarding the privacy of your medication information to the Director of the Health and Wellness Center.

To exercise any of your rights, please submit your request in writing to
The Health and Wellness Director, Jacqueline Newsome-Williams: Newsome-WilliamsJ@trinitydc.edu

Our Responsibilities are:

- To maintain the privacy of your health information
- To provide you with a notice of your privacy practices
- To abide by the terms of this notice
- To notify you if we are unable to agree to a requested restriction
- Accommodate reasonable request you make for communicating information

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Acknowledgement of Receipt of Notice of Privacy Practices

I have been provided with the Notice of Privacy Practices that proves a description of medical information uses and disclosures.
I have been given the opportunity to read and review the notice prior to signing this form.
I understand that Trinity Washington University has the right to change it current practices and these changes will be posted.
I understand I have the right to restrict how some medical information may be disclosed. I understand that Trinity Washington University is not required to agree to my restriction
I understand that I may revoke this acknowledgment in writing, except to the extent action has already been taken.

Full Legal Name: ______________________________________ / **DOB** ______________________________

____/_________________________________

Signature of Patient **Date**