

**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.**

**NEIGHBORHOOD HEALTH PROVIDERS and SUFFOLK HEALTH PLAN  
NOTICE OF PRIVACY PRACTICES**

Information regarding your health care, including payment for health care, is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Any HIV-related information is also protected by a New York law, Article 27-F of the Public Health Law. Under these laws, Neighborhood Health Providers and Suffolk Health Plan may not disclose any health related information about you except as permitted by both laws.

**How and When We May Disclose Your Health Information**

We understand that the privacy of your health information is important. We will take reasonable measures to safeguard your confidential health related information. Generally, we must obtain your written consent before we can disclose any HIV related information about you.

***Public Health Law, Article 27-F:***

- Requires that anyone who takes a voluntary HIV test must first sign a consent form. This means the person understands what the test means and agrees to take it.
- Requires that, with few exceptions, information about a person's HIV status can only be disclosed (shared with others) if the person signs an HIV release form or if the form is signed by the person's legally appointed guardian or healthcare proxy.
- Applies to individuals and facilities that directly provide health or social services and to anyone who receives HIV-related information about a person pursuant to a properly executed HIV release form.
- Requires that any individual or facility whose work is covered by Article 27-F and who receives HIV-related information MUST keep that information confidential as required by the law.

***What is confidential HIV-related information?***

It is any information that shows a person:

- Had an HIV-related test (such as a HIV antibody test, PCR test, CD4 test for HIV, viral load test or other test);
- Has HIV-infection, HIV-related illness, or AIDS;
- Has been exposed to HIV; or
- Has one of these conditions, including information on the individual's contacts.

There are a few circumstances when we can disclose HIV related information about you without your written consent. These are

- For your treatment or the coordination of your care by health care providers (Medical) professionals working on the treatment team with the person's existing provider may discuss a patient's HIV-related information with each other or with their supervisors, but only to give necessary care. A general release is needed to disclose medical information to a provider who is not affiliated with the person's current medical provider.

- For payment such as collecting premiums, determining your eligibility for benefits, reimbursing health care providers that treat you and obtaining payment from other insurers that may be responsible for providing coverage to you
- For our health care operations which includes quality improvement activities, evaluating our health plan performance and resolving any complaints or grievances you may have;
- To the State Department of Health for public health monitoring and partner notifications;
- To an authorized agency in connection with the foster care or adoption of a child;
- For medical education or in connection with organ, tissue or fluid transplants;
- To appropriate authorities when relevant to a report of suspected child or elder abuse or neglect;
- As allowed by a court order;
- In limited circumstances when someone may have been exposed to HIV while on the job;
- In limited circumstances a physician may disclose HIV related information about a minor to the minor's parent or guardian;
- For organ or tissue donation.

We can disclose general health information (other than HIV related information) about you without your written permission in the following circumstances:

- For your treatment or the coordination of your care by health care providers,
- For payment such as collecting premiums, determining your eligibility for benefits, reimbursing health care providers that treat you and obtaining payment from other insurers that may be responsible for providing coverage to you
- For our health care operations which includes quality improvement activities, evaluating our health plan performance and resolving any complaints or grievances you may have;
- As required by state, federal or local law;
- For public health activities;
- For judicial and administrative proceedings and certain law enforcement purposes;
- Through a written agreement to outside contractors (called business associates) that provide us services;
- For specialized government functions such as national security purposes;
- To correctional facilities regarding inmates;
- To funeral directors, coroners and medical examiners;
- To the Food and Drug Administration for product monitoring and recall;
- For Workmen's Compensation
- For research if certain requirements are met;
- To individuals involved in your care.

The following is a list of the ways in which we may use and disclose your health information. In some cases we provided examples of the types of uses or disclosures that fall within a particular category. These examples are intended to help you understand what these categories mean; they do not cover every type of use or disclosure within each category. When we make these disclosures, we must follow federal, state, and local laws that provide special protections for health information relating to certain alcohol and drug abuse treatment.

1. Uses and Disclosures for Payment and Health Care Operations. After we, or one of the government programs in which we participate, has obtained your general consent to use and disclose your health information to administer your benefits and for other purposes permitted by state or federal law, we may use and disclose your health information for the following purposes:

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- a. *Treatment.* For example, if one of our participating health care providers is treating you, we may disclose to this provider health information relating to other health care services you have received that may be relevant to the provider's treatment.
  - b. *Payment.* For example, if a health care provider submits a bill to us for services you received, we may use health information about you to determine whether these services are covered under your benefit plan and the appropriate amount of payment to which the provider may be entitled.
  - c. *Health Care Operations.* For example, we may collect and review records maintained by doctors and hospitals that have treated you to see whether they have provided you with preventive treatment and other important health services that are recommended by medical authorities.
  - d. *Appointment Reminders.* We may use and disclose your health information to remind you about appointments you have made to receive health care services or to encourage you to make such appointments.
  - e. *Treatment Alternatives.* We may use and disclose your health information to tell you about treatment alternatives or other health-related benefits and services that may be of interest to you.
2. Uses and Disclosures Without Your Consent or Authorization. We may use and disclose your health information without your specific written authorization for the following purposes:
- a. *As required by law.* We may use and disclose your health information as required by state, federal or local law.
  - b. *For public health activities.* We may disclose your health information for public health monitoring and activities, such as reporting or preventing disease outbreaks, partner notifications (in the case of HIV related information), reporting births, deaths, child abuse or neglect, domestic violence, potential problems with products regulated by the Food and Drug Administration or communicable diseases.
  - c. *For judicial and administrative proceedings.* We may disclose your health information in the course of any judicial or administrative proceeding in response to a court order, search warrant or subpoena by a court or administrative body.
  - d. *For law enforcement purposes.* We may disclose your health information to a law enforcement official for purposes such as: identifying or locating a suspect, fugitive or missing person or reporting a crime.
  - e. *For health oversight activities.* We may disclose your health information to health oversight agencies for the following activities authorized by law: (1) audits, investigations, inspections, including fraud and abuse investigation; (2) licensing or disciplining actions; (3) civil, administrative or criminal proceedings, or other activities related to the oversight of the health care system; (4) government benefit programs; and (5) compliance with government regulatory programs and civil rights laws.

- f. *To avert a serious threat to health or safety.* We may use or disclose your health information to prevent or lessen a serious and immediate threat to your health or safety or to the health or safety of another person or the general public.
- g. *For specialized government functions.* If you are a member of the armed forces, we may disclose your health information as required by military authorities. We also may disclose your health information to authorized federal officials for national security activities. In addition, we may disclose inmates' health information to correctional institutions in limited circumstances.
- h. *For workers' compensation.* We may use or disclose your health information to comply with workers' compensation laws.
- i. *To individuals involved in your care.* We may disclose your health information to a person who represents you if you tell us to do so.

3. **Your authorization is required for other uses and disclosures.** We will not use or disclose your health information for any purpose **not specified** in this Notice of Privacy Practices **unless we obtain your express written authorization.** If you give us your authorization, **you may revoke it at any time**, in which case we will no longer use or disclose your health information for the purpose you authorized, except to the extent we have relied on your authorization in providing benefits. While you are required to sign a consent form in order to receive benefits from us, we may not refuse to enroll or continue to provide benefits to you if you decide not to sign an authorization form.

### **Your Rights Regarding Your Health Information**

You have the following rights regarding your health information:

1. **Right to See and Copy.** You have the right to see or get a copy of health information about you that we maintain and that we may use in making decisions about your benefits. In certain situations, we may deny your request. We may charge you a reasonable fee for copies to cover our costs. You may ask to inspect or obtain copies of your information by writing to our Member Services address at the bottom of this page.

2. **Right to Request Amendments.** You have the right to request changes to any health information we maintain about you if you state a reason why this information is incorrect or incomplete. If we deny your request to change the information in our records, we will notify you in writing how you can have your objection to our decision included in our records. You may request changes to your health information by writing to our Member Services address at the bottom of this page. Please include the date of the request, your signature or the signature of your representative and the reason for the request.

3. **Right to an Accounting of Disclosures.** You have the right to receive a list of disclosures of your health information that have been made by us. The list will not include disclosures made for certain types of purposes, such as disclosures for treatment, payment or health care operations or disclosures you authorized in writing. Your request should specify the time period for which you want this list, which can be no longer than six years and may not include dates prior to April 14, 2003. The first time you ask for a list of disclosures in any 12-month period, we will provide it for free. If you request additional lists during a 12-month period, we may charge you a fee to cover our costs in providing the additional lists. You may request a list of disclosures by writing to our Member Services address at the bottom of this page. Please include the date of the request, your signature or the signature of your representative and the reason for the request.

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4. Right to Request Restrictions. You have the right to ask to restrict uses or disclosures of your health information for treatment, payment and health care operations. You also have the right to ask to restrict disclosures to family members or to other individuals who are involved in your care. While we may honor your request, we are not required to agree to these restrictions. You may request a restriction on the use or disclosure of your health information by writing to our Member Services address at the bottom of this page. Please include the date of the request, your signature or the signature of your representative and the reason for the request.

5. Right to Request Confidential Communications. You have the right to ask us to send health information to you in a different way or at a different location if you believe that you may be in danger by our ordinary form of communication. For example, if you are afraid that someone living with you may open the mail we send you and harm you as a result, you can ask us to send your mail to a relative's or employer's address. We will require that you make your request in writing. We will accommodate all reasonable requests. You may ask us to send health information to you in a different way or at a different location by writing to our Member Services address at the bottom of this page. Please include the date of the request, your signature or the signature of your representative and the reason for the request.

6. Right to Paper Copy of Notice. You have the right to receive a paper copy of this Notice of Privacy Practices at any time by writing to our Member Services address at the bottom of this page. Please include the date of the request, your signature or the signature of your representative and the reason for the request.

### **Complaints**

If you believe your privacy rights under HIPAA have been violated, you may file a complaint with us by writing to Member Services address on the bottom of the page. We will not take any action against you for filing a complaint. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services, Office for Civil Rights, 26 Federal Plaza, Suite 3313, New York, NY 10278.

If you believe your rights have been violated under Article 27-F (which protects the confidentiality of HIV related information about you), you may file a complaint with the New York State Department of Health and/or file a lawsuit. The Health Department's AIDS Institute has a special investigation unit that takes Article 27-F complaints. Their hotline number is 1-800-962-5065, or you can send a written complaint to Special Investigation Unit, AIDS Institute, New York State Department of Health, 90 Church Street, New York, NY 10007.

### **Changes to this Notice**

We may change the terms of this Notice of Privacy Practices at any time. If we change the terms of this Notice, the new terms will apply to all of your health information, whether created or received by us before or after the date on which the Notice is changed. We will notify you of changes to this Notice by mailing you a copy of the new Notice within 60 days of the date on which it becomes effective.

### **Additional Information**

If you have any questions or would like additional information about this Notice or our privacy practices, please contact our Member Services address on the bottom of this page.

### **Effective Date**

This Notice of Privacy Practices is effective as of November 1, 2010.

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