I acknowledge that I have received a copy of the Troy Fire Protection District Notice of Privacy Practices. I request that payment of authorized Medicare, Medicaid, or any other insurance benefits be made on my behalf to Troy Fire Protection District (TFPD) for any services provided to me by TFPD now or in the future. I understand that I am financially responsible for the services provided to me by TFPD, I agree to immediately remit to TFPD any payment that I receive directly from insurance or any source whatsoever for the services provided to me and I assign all rights to such payments to TFPD. I authorize TFPD to appeal payment denials or other adverse decisions on my behalf without further authorization. I authorize and direct any holder of medical information or documentation about me to release such information to TFPD and the Centers for Medicare and Medicaid Services and its carriers and agents, and/or other payers or insurers as may be necessary to determine these or other benefits payable for any services provided to me by TFPD. A copy of this form is as valid as an original.

Date:

_____

_____ PRINT NAME OF PATIENT

_____ Signature of Patient or Patient's Representative

_____ Relationship to Patient

_____ Street Address

_____ City, State, Zip

Accounting of Disclosures You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and health care operations. To obtain this list, you must
submit your request in writing to the EMS Coordinator. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions You have the right to request
a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend.

We are Not Required to Agree to Your Request If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you may complete and submit *the Request For Restriction On Use/Disclosure Of Medical* Information to the EMS Coordinator.

Right to Request Confidential Communications You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you may complete and submit the *Request For Restriction On Use/ Disclosure Of Medical Information And/Or Confidential Communication* to the EMS Coordinator. We will not ask you
the reason for your request. We will accommodate all
reasonable requests. Your request must specify how or when you wish to be contacted.

Right to a Paper Copy of This Notice You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact the EMS Coordinator.

CHANGES TO THIS NOTICE We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

COMPLAINTS If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact the EMS Coordinator.

You will not be penalized for filing a complaint.

NOTICE OF PRIVACY PRACTICES

Troy Fire Protection District

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

If you have any questions about this notice, please contact our EMS Coordinator at (815) 725-2149, 700 Cottage RD. (RT 59) Shorewood IL 60404

WHO WILL FOLLOW THIS NOTICE This notice describes the I
nformation privacy practices followed by our employees.

YOUR HEALTH INFORMATION This notice applies to the
information and records we have about your health, health status, and the health care and services you receive from us.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health. For example, this includes such things as verbal and written information that we obtain about you and use pertaining to your medical condition and treatment provided to you by us and other medical personnel (including doctors and nurses who give orders to allow us to provide treatment to you). It also includes
information we give to other health care personnel to whom we transfer your care and treatment, and includes transfer of personal health
information via radio or telephone to the hospital or dispatch center as well as providing the hospital with a copy of the written record we create in the course of providing you with treatment and transport.

For Health Care Operations We may use and disclose health information about you in order to run the service and to make sure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staffs in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

SPECIAL SITUATIONS We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

To Avert a Serious Threat to Health or Safety We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
Required By Law We will disclose health information about you when required to do so by federal, state or local law.
Research We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are.
Organ and Tissue Donation If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.
Military, Veterans, National Security and Intelligence If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.
Workers' Compensation We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
Public Health Risks We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental
physical injuries, reactions to medications or problems with products.
Health Oversight Activities We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.
Lawsuits and Disputes If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.
Law Enforcement We may release health
information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.
Coroners, Medical Examiners and Funeral Directors We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.
Information Not Personally Identifiable We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.
Family and Friends We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization*. We
must obtain your *Authorization* separate from any *Consent* we may have obtained from you. If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization* in writing, at any time. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to the EMS Coordinator in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to Amend If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office. To request an amendment, complete and submit a Medical Record Amendment/Correction Form to the EMS Coordinator. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

a) We did not create, unless the person or entity that created the information is no longer available to make the amend amendment.

b) Is not part of the health information that we keep.

c) You would not be permitted to inspect and copy.

d) Is accurate and complete.

EMERGENCIES ONLY—AMBULANCE CREW
Complete this section only if all of the following are true: (the call is an emergency ambulance transport, (2) the patient was physically or mentally incapable of signing, and (3) no authorized representative was available or willing to sign on behalf of the patient at the time of service.

Patient Name:_____

Transport Date:_____

A. Ambulance Crew Member Statement (must be completed by crew member at time of transport)
My signature below indicates that, at the time of service, the patient was physically or mentally incapable of signing, and that none of the authorized representatives were available or willing to sign on the patient's behalf.

Reason patient incapable of signing:_____

_____

Name of Receiving Facility:_____

Time of Receiving Facility:_____

_____Signature of Crewmember

_____

Printed Name of Crewmember

B. Receiving Facility Representative Signature
The patient named on this form was received by this facility at the date and time indicated above. This signature is not an acceptance of financial responsibility for the services rendered to this patient.

_____

Signature of Receiving Facility Representative

_____

Printed Name and Title of Receiving Facility Representative

C. Secondary Documentation (required only if signature in Section B cannot be obtained)
If no facility representative signature is obtained, the ambulance crew should attempt to obtain one or more of the following forms of documentation from the receiving facility that indicates that the patient was transported to that facility by ambulance on the date and time indicated above. The release of this information by the hospital to the ambulance service is expressly permitted by §164.506© of HIPAA.

☒ Facility Face Sheet/Admissions Record

☒ Patient Care Report (signed by representative of facility)

☒ Hospital Log or Other Similar Facility Record

☒ Patient Medical Record