



NOTICE OF PRIVACY PRACTICES

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.

Our facility uses your Protected Health Information for treatment, to obtain payment for our services and for our operational purposes, such as improving the quality of care we provide to you. We are committed to maintaining your confidentiality and protecting your health information. We are required by law to provide you with this Notice which describes our health information privacy practices and those of affiliated health care providers that provide care at our facility.

This Notice applies to all information and records related to your care that our facility workforce members and Business Associates (described below) have received or created. It also applies to health care professionals, such as physicians, and organizations that provide care to you at our facility. It informs you about the possible uses and disclosures of your Protected Health Information and describes your rights and our obligations regarding your Protected Health Information.

We are required by law to:

- maintain the privacy of your Protected Health Information;
- provide to you this detailed Notice of our legal duties and privacy practices relating to your Protected Health Information; and
- abide by the terms of the Notice that are currently in effect. We reserve the right to change the terms of this Notice, and will notify you or your personal representative by letter if we make any material changes to the Notice.

I. WITH YOUR CONSENT WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

You will be asked to sign a Consent allowing us to use and disclose your Protected Health Information to others to provide you with treatment, obtain payment for our services, and run our health care operations. Here are examples of how we may use and disclose your health information.

For Treatment. Our staff and affiliated health care professionals may review and record information in your record about your treatment and care. We will use and disclose this health information to health care professionals in order to treat and care for you. For example, a physician may consult with another physician located at another location to determine how to best diagnose and treat you.

For Payment. Our facility may use and disclose your Protected Health Information to others in order for the facility to bill for your health care services and receive payment. For example, we



may include your health information in our claim to Blue Cross/Blue Shield or Medicare in order to receive payment for services provided to you. We may also disclose your health information to other health care providers so that they can receive payment for your services.

For Health Care Operations. We may use and disclose your Protected Health Information to others for our facility's business operations. For example, we may use Protected Health Information to evaluate our facility's services, including the performance of our staff, and to educate our staff.

II. WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR OTHER SPECIFIC PURPOSES

Business Associates. We may share your Protected Health Information with our vendors and agents who help us with obtaining payment or carrying out our business functions. For example, we may give your health information to a billing company to assist us with our billing for services, or to a law firm or an accounting firm that assists us in complying with the law and or improving our services.

Facility Directory. Unless you object, we may include general information about you in our facility directory. This information may include your name, location in the facility, and religious affiliation. We may release information in our directory, except for your religious affiliation, to people who ask for you by name. Your religious affiliation may be given to any member of the clergy even if they don't ask for you by name.

Family and Friends Involved in Your Care. Unless you object, we may disclose your Protected Health information to a family member or close personal friend, including clergy, who is involved in your care or payment for that care.

Disaster Relief. We may disclose your Protected Health Information to an organization assisting in a disaster relief effort.

Public Health Activities. We may disclose your Protected Health Information for public health activities including the reporting of disease, injury, vital events, and the conduct of public health surveillance, investigation and/or intervention. We may also disclose your information to notify a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition if a law permits us to do so.

Health Oversight Activities. We may disclose your Protected Health Information to health oversight agencies authorized by law to conduct audits, investigations, inspections and licensure actions or other legal proceedings. These agencies provide oversight for the Medicare and Medicaid programs, among others.

Reporting Victims of Abuse, Neglect or Domestic Violence. If we have reason to believe that you have been a victim of abuse, neglect or domestic violence, we may use and disclose your Protected Health Information to notify a government authority if required or authorized by law, or if you agree to the report.



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Coroners, Medical Examiners, Funeral Directors, Organ Procurement Organizations. We may release your health information to a coroner, medical examiners, funeral director or, if you are an organ donor, to an organization involved in the donation of organs and tissue.

To Avert a Serious Threat to Health or Safety. We may use and disclose your Protected Health Information when necessary to prevent a serious threat to your health or safety or the health or safety of the public or another person. However, any disclosure would be made only to someone able to help prevent the threat.

Military and Veterans. If you are a member of the armed forces, we may use and disclose your Protected Health Information as required by military command authorities. We may also use and disclose Protected Health Information about foreign military personnel as required by the appropriate foreign military authority.

Workers' Compensation. We may use or disclose your Protected Health Information to comply with laws relating to workers' compensation or similar programs.

National Security and Intelligence Activities; Protective Services. We may disclose health information to authorized federal officials who are conducting national security and intelligence activities or as needed to provide protection to the President of the United States, or other important officials.

As Required By Law. We will disclose your Protected Health Information when required by law to do so.

III. YOUR AUTHORIZATION IS REQUIRED FOR OTHER USES OF YOUR PROTECTED HEALTH INFORMATION

We will use and disclose your Protected Health Information other than as described in this Notice or required by law only with your written Authorization. You may revoke your Authorization to use for disclose Protected Health Information in writing, at any time. To revoke your Authorization, contact the Medical Records/Health Information Management (HIM) staff. If you revoke your Authorization, we will no longer use or disclose your Protected Health Information for the purposes covered by the Authorization, except where we have already relied on the Authorization.

Law Enforcement. We may disclose your Protected Health Information for certain law enforcement purposes or other specialized governmental functions.

Judicial and Administrative Proceedings. We may disclose your Protected Health Information in the course of certain judicial or administrative proceedings.

Research. In general, we will request that you sign a written authorization before using your Protected Health Information or disclosing it to others for research purposes. However, we may use or disclose your health information without your written authorization for research purposes provided that the research has been reviewed and approved by a special Privacy Board or Institutional Review Board.



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IV. YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights with respect to your health information. If you wish to exercise any of these rights, you should make your request to the Medical Records/HIM Director.

Right of Access to Protected Health Information. You have the right to request, either orally or in writing, to inspect and obtain a copy of your Protected Health Information, subject to some limited exceptions. We must allow you to inspect your records within 24 hours of your request. If you request copies of the records, we must provide you with copies within 2 days of that request. We may charge a reasonable fee for our costs in copying and mailing your requested information.

In certain limited circumstances, we may deny your request to inspect or receive copies. If we deny access to your Protected Health Information, we will provide you with a summary of the information, and you have a right to request review of the denial. We will provide you with information on how to request a review of our denial and how to file a complaint with us or the Secretary of the Department of Health and Human Services.

Right to Request Restrictions. You have the right to request restrictions on the way we use and disclose your Protected Health Information for our treatment, payment or health care operations. You also have the right to restrict your Protected Health Information that we disclose to a family member, friend or other person who is involved in your care or the payment for your care.

We are not required to agree to your requested restriction, and in some cases, the law may not permit us to accept your restriction. However, if we do agree to accept your restriction, we will comply with your restriction in most situations. We may not be required to honor your restriction in the following situations: (1) you are being transferred to another health care institution; (2) the release of records is required by law, or (3) the release of information is needed to provide you emergency treatment.

Right to an Accounting of Disclosures. You have the right to request an "accounting" of our disclosures of your Protected Health Information. This is a listing of certain disclosures of your Protected Health Information made by the facility or by others on our behalf, but does not include disclosures made for treatment, payment and health care operations or certain other exceptions.

You must submit a request in writing, stating a time period beginning after April 13, 2003 that is within six years from the date of your request. For example, you may request a list of disclosures the facility made between May 1, 2003 and May 1, 2004. You are entitled to one free accounting within one 12-month period. For additional requests, we may charge you our costs.

We will usually respond to your request within 60 days. Occasionally, we may need additional time to prepare the accounting. If so, we will notify you of our delay, the reason for the delay, and the date when you can expect the accounting.



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Right to Request Amendment. If you think that your Protected Health Information is not accurate or complete, you have the right to request that the facility amend such information for as long as the information is kept in our records. Your request must be in writing and state the reason for the requested amendment. We will usually respond within 60 days, but will notify you within 60 days if we need additional time to respond, the reason for the delay and when you can expect our response. We may deny your request for amendment, and if we do so, we will give you a written denial including the reasons for the denial and an explanation of your right to submit a written statement disagreeing with the denial.

Right to a Paper Copy of This Notice. You have the right to obtain a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time.

Right to Request Confidential Communications. You have the right to request that we communicate with you concerning personal health matters in a certain manner or at a certain location. For example, you can request that we speak to you only at certain private locations in the facility. We will accommodate your reasonable requests.

V. COMPLAINTS

If you believe that your privacy rights have been violated, you may file a complaint in writing with us or with the Office of Civil Rights in the U.S. Department of Health and Human Services. To file a complaint with the facility, contact Stephen Mercurio, Vice President 800-826-2013. No one will retaliate or take action against you for filing a complaint.

VI. CHANGES TO THIS NOTICE

We will promptly revise and distribute this Notice whenever there is a material change to the uses or disclosures, your individual rights, our legal duties, or other privacy practices stated in this Notice. We reserve the right to change this Notice and to make the revised or new Notice provisions effective for all Protected Health Information already received and maintained by the facility as well as for all Protected Health Information we receive in the future. We will post a copy of the current Notice in the facility. In addition, we will provide a copy of the revised Notice to all residents by delivering a hard copy to them or their personal representatives.

VII. FOR FURTHER INFORMATION

If you have any questions about this Notice or would like further information concerning your privacy rights, please contact Ms. Marsha Noren, Administrator at 631-361-2020.

Effective Date of this Notice: April 13, 2003



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**RESIDENT'S WRITTEN ACKNOWLEDGMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

Resident Name: _____

I acknowledge that I have received a copy of the SMITHTOWN CENTER FOR REHABILITATION & NURSING CARE's Notice of Privacy Practices and have been advised of how the facility [and the other named individuals and organizations listed in the Notice] will handle my Protected Health Information. I have also been advised of my rights to obtain access to and control my Protected Health Information. I understand that I may receive other notices which describe how the facility will handle specialized forms of Protected Health Information such as HIV/AIDS-related, alcohol and substance abuse, and genetic information and psychotherapy notes.

SIGNATURE

I have received a copy of the SMITHTOWN CENTER FOR REHABILITATION & NURSING CARE's Notice of Privacy Practices. I have had an opportunity to ask questions about the Notice and the use or disclosure of my Protected Health Information.

Signature of Resident or Personal Representative: _____

Print Name of Resident or Personal Representative: _____

Description of Personal Representative's Authority: _____

Date _____

CONTACT INFORMATION

Contact information of the personal representative who signed this form:

Address:

Telephone: _____ (Daytime) _____ (Evening)

For Facility Use Only:

Date Notice Provided _____

Name of Facility Staff Member _____

Title _____



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**CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION
 FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS**

I authorize the use and disclosure of my Protected Health Information by the Facility listed above and by the Facility's staff and Business Associates for purposes of treatment, payment and health care operations.

Resident Name: _____

Important Information Regarding this Consent:

1. I understand New York laws require my consent before the facility may use or disclose my Protected Health Information for treatment, payment or health care operations.
2. I understand that this information may be used or disclosed by the facility to:
 - plan my care and treatment;
 - communicate among various health care professionals who are involved in my care or treatment;
 - obtain payment for care provided by the facility or for the payment activities of another health care provider or entity;
 - provide information to my health insurance company or plan;
 - obtain payment from my health insurance company or plan; and
 - assess and review the quality of my care.
3. I understand that my signature on the consent is required in order for me to receive care from the facility and that the facility may condition my treatment on obtaining my consent for use and disclosure of my Protected Health Information for treatment, payment and health care operations.
4. I understand that further information on the facility's uses and disclosures of my Protected Health Information for treatment, payment and health care operations is included in the facility's Notice of Privacy Practices.

SIGNATURE

I have read and understand the terms of this consent. I have had an opportunity to ask questions about the use or disclosure of my Protected Health Information.

Signature of Resident or Personal Representative: _____

Print Name of Resident or Personal Representative: _____

Description of Personal Representative's Authority: _____

Date: _____

CONTACT INFORMATION

Contact information of the personal representative who signed this form:

Address: _____

Telephone: _____ (Daytime) _____ (Evening)

For Facility Use Only:

Date Facility Obtained Consent: _____

Name and Title of Person Obtaining Consent _____

Action Taken by Facility on Consent