Case Number_____
(office use only)

EAP Client Registration Form

All information you provide is strictly confidential

Employee Organization: _____

Client Information

Name: _____ Date of Birth: _____

If under 18 yrs., legal guardian name: _____

Relationship to Employee: ☐ Self ☐ Family Member

Home Address: _____
Street City/Town Zip Code

Preferred Phone Number: _____ ☐ Cell ☐ Work ☐ Home

Ethnicity: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Caucasian/White
☐ Hispanic/Latino ☐ Native Hawaiian/Other Pacific Islander ☐ Multi Racial ☐ Other

Gender: _____ Pronouns: _____

Relationship Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Partnered ☐ Widowed

*If attending session, spouse/partners' name (see *attached addendum*)

Referred by: ☐ Supervisor ☐ Self ☐ HR ☐ Disability Management ☐ PCP ☐ Coworker ☐ Family
☐ Other - please specify: _____

Have you or a member of your family used EAP services in the past? ☐ Yes ☐ No

Emergency Contact Name and Phone Number: _____

Primary Care Physician Name and Phone Number: _____

Position Title:_____

Insurance Provider: ☐ Aetna ☐ Excellus ☐ Medicaid ☐ MVP ☐ None ☐ Other: _____

Personnel Actions Taken (employee only): ☐ Counseled ☐ Warning ☐ Suspension ☐ Demotion
☐ Termination ☐ Resignation ☐ None ☐ Other

UR Employee Information

(**DO NOT complete if you are not employed by UR**)

Work Location: ☐ River Campus ☐ Tech Park ☐ URMC ☐ UR Other Union Member: ☐ Yes ☐ No

Work Status: ☐ FT ☐ PT ☐ Temp ☐ Per Diem ☐ Volunteer ☐ Resident/Fellow

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Case Number_____
(office use only)

EAP Pre-Screen Survey

1. Briefly explain why are you seeking EAP services :_____
_____
_____
_____
_____

2. The following is a list of general symptoms that people may experience. Please check all that you have experienced over the last 1-4 weeks.

- ☐ Repetitive, senseless thoughts behaviors
- ☐ Irrational thoughts
- ☐ Sad/depressed/down in the dumps
- ☐ Trembling/shakiness
- ☐ Aggressive/violent behavior
- ☐ Constant worry/fear
- ☐ Irritability
- ☐ Tense/nervous/cranky
- ☐ Feeling in a dreamlike state
- ☐ Concentration difficulties
- ☐ Memory problems
- ☐ Sweating
- ☐ Dizzy/lightheaded
- ☐ Insomnia/trouble sleeping
- ☐ Sleeping too much
- ☐ Fatigue/lack of energy
- ☐ Decrease in motivation
- ☐ Fear of losing control
- ☐ Fear of going crazy
- ☐ Change in weight
- ☐ Helpless feelings
- ☐ Frequent crying/weeping
- ☐ Frequent thoughts of suicide/death
- ☐ Fear of impending doom
- ☐ Worthless feelings
- ☐ Hopeless Feelings
- ☐ Lack/loss of interest in things
- ☐ Feelings like is not worth living
- ☐ Decrease in sex drive
- ☐ Frequent negative thinking
- ☐ Fear of dying
- ☐ Seeing things that are not real
- ☐ Hearing things that are not real

3. How many times have you been unexpectedly absent or tardy in the last 30 days due to physical or mental health reasons? ☐ No Days ☐ 1-5 Days ☐ 6-10 Days ☐ 11-15 Days ☐ 16+ Days

4. How did you hear about EAP services?

- ☐ HR
- ☐ Website
- ☐ Brochure/Poster
- ☐ Family Member
- ☐ HRBP
- ☐ BHP
- ☐ Reputation
- ☐ Union Rep
- ☐ PCP
- ☐ Orientation/Presentation
- ☐ Condition Management
- ☐ Other (please specify): _____
- ☐ Supervisor
- ☐ Co-Worker
- ☐ Lifestyle Program
- ☐ Biometric Screening
- ☐ Attended EAP Previously

5. Is the reason you are seeking EAP services work related?

- ☐ Work related concern that **is** impacting my personal life
- ☐ Work related concern that **is not** impacting my personal life
- ☐ Personal concern that **is not** impacting my work performance
- ☐ Personal concern that **is** impacting my work performance

6. If your concern is impacting your work performance, which of the following work performance issues have you experienced in the past 12 months?

☐ Not impacting work performance ☐ Resulted in the use of sick time
☐ Quality/Quantity of work decreased ☐ Problem relating to other employee
☐ Other (please specify): _____

7. During the last four weeks, how much difficulty have you had doing your work or other regular daily activities as a result of you physical health?
   ☐ None at all ☐ A little bit ☐ Some ☐ Quite a bit ☐ Could not do daily work
8. During the last four weeks, to what extent have you accomplished less than you would like in your work or in other daily activities as a result of emotional concerns (such as feeling depressed or anxious)?
   ☐ None at all ☐ Slightly ☐ Moderately ☐ Quite a bit ☐ Extremely
9. During the last four weeks, to what extent has your physical or emotional health concerns interfered with your normal social activities with family, friends, neighbors or groups?
   ☐ None at all ☐ Slightly ☐ Moderately ☐ Quite a bit ☐ Extremely
10. Have you had any acts of violence directed against you? ☐ Yes ☐ No
11. How many alcoholic beverages do you consume each week? _____
12. Do you use recreational drugs or substances? ☐ Yes ☐ No
13. Are you currently on any medications? _____
14. Are you a veteran? ☐ Yes ☐ No
15. Do you have a disability that you would like us to be aware of? ☐ Yes ☐ No
    Reasonable accommodations needed for your session: _____
16. Was your call/email to EAP answered promptly?
    ☐ Yes, immediately ☐ Yes, within an 8 hour timeframe ☐ No
17. Was your appointment scheduled in a timely manner?
    ☐ Yes, within 3 business days ☐ No, I requested a specific date, time and/or counselor
    ☐ Yes, within 5 business days ☐ No appointment was available within 5 days
18. Would you have taken time off from work to deal with your concerns if EAP were no available?
    ☐ Yes ☐ No
19. If EAP were not available, where would you go to seek assistance? (please check only one)
    ☐ Family member/Friend ☐ Supervisor/Co-worker ☐ PCP
    ☐ Professional in the community ☐ I wouldn't know where to go
    ☐ Behavioral Health Partners (UR only) ☐ Other (please specify): _____
20. Are you interested in receiving our EAP newsletter? ☐ Yes ☐ No

    If so, please include the email address that you would like the newsletter to be delivered to:
    _____

To our valued client:

To provide the best services, we would like to measure the impact that EAP has on our clients' lives. We would appreciate you completing the 5 question survey below prior to your EAP session as well as a similar follow up survey in 60 to 90 days. **Your identity will remain confidential**. Your employer will **NOT** be allowed to view responses.

May we contact you via email in 60 to 90 days to complete a similar follow up survey?

_____ Yes preferred email address _____

_____ No

Thank you for your participation.

WORKPLACE OUTCOME SUITE – 5 ITEM VERSION

GENERAL INSTRUCTIONS
Below is a series of statements that refer to aspects of your work and life experience that may be affected by the personal problems you want to address at the EAP during the past 30 days. Please read each item carefully and answer as accurately as you can.

			NUMBER OF HOURS
AB	1.	For the period of the past 30 days, please total the number of hours your personal concern caused you to miss work. Include complete eight-hour days and partial days when you came in late or left early.	

		INSTRUCTIONS FOR ITEMS 2 – 5 The following statements reflect what you may do or feel on the job or at home. Please indicate the degree to which you agree with each of the statements for the past 30 days. Use the 1-5 response key to the right.	STRONGLY DISAGREE	SOMEWHAT DISAGREE	NEUTRAL	SOMEWHAT AGREE	STRONGLY AGREE
PR	2.	My personal problems kept me from concentrating on my work.	1	2	3	4	5
WE	3.	I am often eager to get to the work site to start the day.	1	2	3	4	5
LS	4.	So far, my life seems to be going very well.	1	2	3	4	5
WD	5.	I dread going into work.	1	2	3	4	5

UNIVERSITY of ROCHESTER

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

Client Name: _____ DOB: _____

I have been provided with the URMC & Affiliates Notice of Privacy Practices

Clients Signature: _____ Date: _____

OR

Signature of personal representative: _____

Relationship to client: _____ Date: _____

****

If signature not obtained, please indicate reason:

- ☐ Client Declined
- ☐ Emergency Situation
- ☐ Other

(Note: This document must be retained for 6 years in accordance with the HIPAA Privacy Rule)

STATEMENT OF UNDERSTANDING

Your employer's employee assistance program (EAP), provided through Strong Behavioral Health, offers professional guidance to employees and their families whose personal or work-related problems have become hard to manage alone. EAP is a confidential, work-site-based program. Employees and/or their family members may meet with an EAP professional at no cost. The number of visits allowed per year is specific to your employer.

Meetings with an EAP counselor are offered at no direct cost to the employee or family member. **If a client needs long-term counseling or specialized service(s), the EAP will assist in locating a resource for the client in the community.** It is the responsibility of the client to pay for any service(s) provided by outside resources. Insurance coverage provided to employees may defray some or all of the cost of service(s).

During the initial consultation, an EAP counselor will evaluate your needs and make an appropriate referral, if necessary. If your issue can be resolved within the number of visits available, the EAP counselor will work directly with you.

Confidentiality: For information regarding the confidentiality of our services and the use or disclosure of your protected health information, please refer to the University of Rochester Medical Center & Affiliates Notice of Privacy Practices.

Participation in EAP is voluntary. In the event you have been offered or mandated EAP services by your supervisor, refusal to accept or utilize the EAP is not, in itself, a cause for disciplinary action. However, such refusal or failure to accept help may be taken into consideration when evaluating subsequent unsatisfactory performance or behavior. Furthermore, you are also advised that participation in EAP does not constitute a waiver of your employer's right to take disciplinary measures in the event of unsatisfactory performance or behavior prior to, during or subsequent to your participation in EAP.

☐ **I have read this Statement of Understanding and understand its contents.**

Signature of Client	Date	Relationship to client (Parent, Guardian, Spouse, Self, etc)

No Signature was obtained due to:

☐ Client's condition/capacity ☐ No representative ☐ Refused to sign

CLIENT E-MAIL CONSENT FORM

Client Name: _____

Client E-mail: _____

Personal Representative*:
Name: _____

Relationship: _____

E-Mail: _____
**see HIPPA Policy OP16 Personal Representative*

1. RISK OF USING E-MAIL

Transmitting Client information by E-mail has a number of risks that Clients should consider. These include but are not limited to, the following:
a) E-mail can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
b) E-mail senders can easily misaddress an E-mail.
c) Backup copies of E-mail may exist even after the sender of the recipient has deleted his or her copy.
d) Employers and on-line services have a right to inspect E-mail transmitted through their systems.
e) E-mail can be intercepted, altered, forwarded or used without authorization or detection.
f) E-mail can be used to introduce viruses into computer systems.

2. CONDITIONS FOR THE USE OF E-MAIL

The Clinician cannot guarantee but will use reasonable means to maintain security and confidentiality of E-mail information sent and received. The Client and Clinician must consent to the following conditions:
a) E-mail is not appropriate for urgent or emergency situations. The Clinician cannot guarantee that any particular E-mail will be read or responded to:
b) E-mail must be concise. The Client should schedule and appointment if the issue is too complex or sensitive to discuss via E-mail.
c) E-mail communications between Client and Clinician will be filed in the Client's permanent medical record.
d) The Client's messages may also be delegated to another Clinician or staff member for response. Office staff may also receive and read or respond to Client messages.
e) The Clinician will not forward Client-identifiable E-mails outside of the URMC healthcare system without the Client's prior written consent, except as authorized or required by law.
f) The Client should not use E-mail for communication regarding sensitive medical information.
g) It is the Client's responsibility to follow up and/or schedule an appointment if warranted.
h) Recommended uses of Client-to-Clinician, E-mail should be limited to:

1. Appointment requests
2. Prescription refills
3. Requests for information
4. Non-Urgent health care questions
5. Updates to information or exchange of non-critical information such as laboratory values, immunization, etc…

3. INSTRUCTIONS

To communicate by E-mail, the Client shall:
a) Avoid use of his/her employer's computer.
b) Put the Client's name in the body of the E-mail
c) Put the topic (e.g., medical question, billing question) in the subject line
d) Inform the Clinician of changes in the Client's E-mail address.
e) Take precautions to preserve the confidentiality of E-mail
f) Contact the Clinician's office via conventional communication methods (phone, fax, etc…) if the Client does not receive a reply within a reasonable period of time.

4. CLIENT ACKNOWLEDGEMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of E-mail between the Clinician and me. I consent to the conditions and instructions outlined here, as well as any other instructions that the Clinician may impose to communicate with me by E-mail. I agree to use on the pre-designated e-mail address specified above. Any questions I may have had were answered.

_____ _____

Client or Personal Representative **Date**

UR Medicine EAP
Life-Work Connections/EAP

TELEHEALTH CONSENT

This consent is for all telehealth services provided by UR Medicine EAP

1. I understand that my Employee Assistance Program (EAP) provider has invited me to engage in a telehealth appointment/consultation to provide assessment and short term counseling.

2. My EAP provider has explained to me that video conferencing technology will not be the same as a direct patient provider visit due to the fact that I will not be in the same room as my EAP provider.

3. I understand that there are risks associated with use of this technology such as interruptions, technical difficulties, and inability to obtain information sufficient for decision making about my problem and that all possible precautions will be taken to minimize these risks. In addition, my EAP provider or I can discontinue the telehealth visit if it is felt that the information obtained through the telehealth connection is not adequate for decision-making or for implementing management of my issue(s). In that event, we will complete the session by phone or schedule an in-person appointment at the EAP location where adequate assessment and short term counseling can be provided,

4. I understand that the information I provide may be shared only with other individuals at EAP for scheduling purposes.

5. The alternatives to a telehealth appointment/consultation have been explained to me.

By signing this form, I certify that:

- I have read or had this form read and/or had this form explained to me
- I fully understand its contents including the risks and benefits of the telehealth appointment/consultation
- I have been given ample opportunity to ask questions and that all questions have been answered to my satisfaction.
- I consent to this telehealth appointment/consultation.
- I have been provided with the University of Rochester Medical Center and Affiliates Notice of Privacy Practices.

Patient/Parent/Guardian Signature	Date	Time

TO BE COMPLETED BY STAFF
No signature was obtained due to:
0 Impractical, verbal consent given

Staff Signature	Date	Time

& Affiliates

NOTICE OF PRIVACY PRACTICES

As required by the Health Insurance Portability & Accountability Act (HIPAA) of 1996
Effective September1, 2013

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 applies to the following facilities:

- Strong Memorial Hospital
- Highland Hospital
- Physician practices owned by hospitals listed
- University of Rochester Medical Faculty Group
- University of Rochester Dental Faculty Group
- University Health Service
- Eastman Dental Center
- Highland Apothecary
- Highlands at Brighton
- Highlands Living Center
- Laurelwood at the Highlands
- Meadowbrook Adult Day Care
- University of Rochester School of Nursing and Community Nursing Center
- Finger Lakes Visiting Nurse Service
- Finger Lakes Home Care
- Visiting Nurse Service of Rochester and Monroe County
- Community Care of Rochester
- University of Rochester School of Medicine & Dentistry
- Mt. Hope Family Center
- F.F. Thompson Hospital
- M.M. Ewing Continuing Care Center

These facilities may share medical information with each other for treatment, payment or health care operations as described in this Notice.

WHO WILL FOLLOW THE TERMS OF THIS NOTICE

- All health care professionals, employees, students, volunteers and other personnel from these facilities authorized to access your medical record.
- Independent health care providers not employed by URMC & Affiliates who are involved in your care while practicing in one or more of our facilities (such as physicians).
- Other entities that provide health care services to you in a way that is integrated with our services at one or more of our facilities and their health care professionals, employees, students, volunteers and other personnel.

OUR PLEDGE REGARDING YOUR MEDICAL INFORMATION

We are required by law to:

- Make sure that medical information that identifies you is kept private;
- Give you this Notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of this Notice.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we may use and disclose your medical information:

- **Treatment**. We may use your medical information to provide you with medical treatment or services. We may disclose your medical information to others who are involved in taking care of you. For example, a doctor treating you may need to share your medical information (such as x-rays, lab work, prescriptions) with another person to coordinate your care.
- **Payment**. We may use and disclose medical information so that services can be billed. For example, we may need to give information to your health plan about services you received so your health plan can pay us. We may also tell your health plan about a planned treatment to determine whether your plan will cover the treatment.
- **Health Care Operations**. We may use and disclose medical information about you for health system operations. For example, we may use your information to review our treatment and services, to assess the care and services we offer and to educate health care professionals or trainees.
- **Business Associates**. We may disclose your health information to contractors, agents and other associates who need information to assist us in carrying out our business operations. Our contracts with them require that they protect the privacy of your health information.

- **Appointment Reminders**. In the course of providing treatment to you, we may use your health information to contact you (e.g.: by phone or postcard) with a reminder that you have an appointment for treatment or services.
- **Health-related Benefits and Treatment Alternatives**. We may use and disclose medical information to tell you about or recommend health-related benefits, services or treatment alternatives that may be of interest to you.
- **Fundraising Activities**. We may use information about you to contact you in an effort to raise money for one or more of our facilities. We may also disclose information to a related foundation so they may contact you for fundraising. We may use or disclose demographic and contact information (such as your name, address, phone, gender), the date and department of service (such as cardiology or pediatrics), and your treating physician. Any fundraising communications you receive will include information on how to elect not to receive further fundraising contacts, or you may call 1-800-598-1330 at any time to opt out of fundraising communications.
- **Patient Information Directory**. While you are a hospital patient, your name, location, general condition (e.g., satisfactory) and your religious affiliation will be included in a patient information directory. Directory information, except for your religious affiliation, may be released to people who ask for you by name. Your religious affiliation may also be provided to members of the clergy of your congregation, even if they don't ask for you by name. We will give you the opportunity to object to being included in the directory, unless an emergency situation prevents us from asking you.
- **Individuals Involved in Your Care or Payment for Your Care**. If you do not object, we may release medical information about you to a friend or family member who is involved in your care or payment for your care. We may also tell your family or friends your condition and that you are in the hospital. During a disaster (e.g., a flood), medical information may be disclosed to an authorized public or private entity authorized by law or its charter to assist with relief efforts (such as the Red Cross).
- **Research**. We may use and disclose medical information about you for research purposes. In most cases we will ask for your written authorization. However, under some circumstances we may use and disclose your health information without your written authorization if doing so poses minimal risk to your privacy. We may also release your medical information without your written authorization to people who are preparing a research project, so long as any information identifying you does not leave our facility. The researchers may use this information to contact you to ask if you want to participate in such research.
- **Incidental Disclosures**. Disclosures of your information may occur during or as an unavoidable result of otherwise permissible uses or disclosures of your health information. For example, during the course of your treatment, other patients in the area may see or overhear discussion of your health information despite using reasonable safeguards.
- **Personal Representatives**. We may disclose your health information to your personal representative who has authority to act on your behalf under applicable law.
- **Marketing**. We may use your information for certain limited marketing purposes, such as face-to-face communication. For other marketing activities we will obtain your authorization.

**IN SPECIAL SITUATIONS:*

- **As Required by Law**. We may disclose medical information about you without your authorization when required to do so by federal, state or local law.
- **Victims of Abuse or Neglect**. We may release your health information to a public health authority authorized to receive reports of abuse or neglect.
- **Workers' Compensation**. We may release medical information about you to programs that provide benefits for work-related injury or illness.
- **Public Health Purposes**. We may disclose medical information about you for public health activities related to prevention or control of disease, injury or disability. For example, we report certain communicable diseases to the Department of Health.
- **Health Oversight Activities**. We may disclose your medical information to health oversight organizations authorized to conduct audits, investigations, and inspections of our facilities.
- **Lawsuits and Disputes**. If you are involved in a lawsuit or a dispute, we may disclose your medical information in response to a court or administrative order, subpoena or other lawful process.
- **Law Enforcement**. We may release health information for law enforcement purposes in limited circumstances.
- **To Avert a Serious and Imminent Threat to Health or Safety**. We may use your health information or share it with others when necessary to prevent a serious and imminent threat to your health or safety, or the health or safety of another person or the public.
- **Organ and Tissue Donation**. We may release medical information to organizations that handle organ, eye or tissue donation and transplantation.

- **Coroners, Medical Examiners and Funeral Directors**. We may disclose health information to funeral directors, coroners and medical examiners as permitted by law to carry out their duties.
- **Inmates**. If you are an inmate of a correctional facility, we may disclose to the institution or agents of the institution health information necessary for your health and the health and safety of other individuals.
- **Disclosures to Schools**. Student immunization information may be disclosed to a school without written authorization if state law requires the school to have immunization records and the patient or personal representative's written or oral agreement is documented.
- **Sale of Protected Health Information**. We may only sell your protected health information in very limited circumstances without your written authorization, such as if the covered entity is sold.
- **Military and Veterans**. If you are or have been a member of the armed forces, we may release your medical information as required by the Departments of Defense, Transportation or Veterans Affairs.
- **Protective Services for the President and Others**. We may disclose health information about you to authorized federal officials for the provision of protective services to the President, foreign heads of state or certain other persons.
- **National Security and Intelligence Activities**. We may disclose health information about you to authorized federal officials for intelligence, counterintelligence and other national security activities required by law.

ELECTRONIC HEALTH CARE RECORDS

Some or all of your medical information may be created and/or stored in an electronic format. When permissible for valid purposes (e.g., providing treatment or billing for services) your health care providers may access your medical information electronically. Other healthcare providers outside URMC & Affiliates caring for you may also receive access to your electronic health records for purposes outlined above.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Receive Copies. You may ask to inspect and to receive copies of medical information that may be used to make decisions about your care, including your medical and billing records.

To inspect or receive copies of your medical information, submit your request in writing to the Health Information Management (Medical Records) Department at the facility keeping your medical information. We may charge a fee for the costs of copying, mailing or other supplies associated with your request for copies. You may not be denied a copy if you are unable to pay. You may request an electronic copy of your record and it will be provided in an electronic format if it is readily producible; otherwise you will be provided with a printed copy.

We may deny your request to inspect or receive copies in certain limited circumstances. If your request is denied, you may ask that the denial be reviewed. Another licensed health care professional who we choose will review your request and the denial. The person conducting the review will not be the person who denied your request. You have additional rights to appeal a denial to the New York State Department of Health.

Right to Amend. If you feel your medical information is incorrect or incomplete, you may ask to amend the information for as long as we maintain the information. Your request must be made in writing to the Health Information Management Department of the facility keeping your medical information. You must also provide a reason that supports your request.

We may deny your request if the information:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for us;
- Is not part of the information that you would be permitted to inspect or receive copies; or
- Is accurate and complete.

If your request to amend your record is denied, you will have the right to have certain information related to your requested amendment included in your records. These rights will be explained to you in the written denial notice.

Right to a Listing of Persons Receiving Your Medical Information. You may request an "accounting of disclosures" of medical information released about you. An accounting of disclosures does not include disclosures made:

- to you or your personal representative;
- with your written authorization;
- for treatment, payment or health care operations;
- from the patient directory;

- to your family or friends involved in your care or payment for your care;
- incidental to permissible uses or disclosures; or
- about inmates to correctional institutions or law enforcement officers.

To request this list, submit your request in writing to the Health Information Management Department at the facility keeping your medical information. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a 12-month period will be free. We may charge you for the costs of providing additional lists. We will notify you of the cost involved and you may withdraw or change your request before you are charged any fees.

Right to Request Restrictions.

- You have the right to request restrictions on how we use or disclose your health information to treat your condition, collect payment for your treatment or for our health care operations. We are not required to agree to your request. If we do agree, we will fulfill your request unless the information is needed to provide you emergency treatment. You may direct your written request to the Health Information Management Department of the facility keeping your medical record.
- You have the right to restrict disclosure of your medical information to your health plan for payment when you make a written request and pay for the service out-of-pocket in full prior to or at the time of the service, or if you make payment arrangements at the time of the service subject to approval of URMC & Affiliates that are complied with in a timely manner. We will comply with this restriction unless the disclosure is required by law.

Right to Request Confidential Communications. You may request that we communicate with you about medical matters in an alternative way or at an alternative location (for example, you may wish to be contacted at work rather than at home). Your request should be directed to the area that would handle the communication. You do not need to provide a reason for your request. Reasonable requests will be accommodated.

Right to Breach Notification. You have the right to be notified of a breach of your unsecured protected health information, with a few limited exceptions. A breach is defined as unauthorized acquisition, access, use or disclosure of protected health information in a manner not permitted, unless there is a low probability that the privacy or security of your protected health information has been compromised.

Right to a Paper Copy of this Notice. You may obtain a copy of this Notice at the University of Rochester Medical Center's website, or you may also request a paper copy of this Notice at the location where you receive care.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice. We may 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. The current Notice will be displayed and available to you.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a privacy-related complaint with us, you may call the URMC and Affiliates Integrity Hotline at 585-756-8888 or toll free at 866-567-4202. All complaints to the Department of Health and Human Services must be submitted in writing. You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you provide us your authorization to use or disclose medical information about you, you may revoke that permission, in writing, at any time. However, we are unable to take back any disclosures we have already made with your permission. Your health information may also be disclosed to the Secretary of Department of Health and Human Services for the purpose of investigating or determining URMC & Affiliates compliance with HIPAA.

If you have any concerns about the uses of your medical information, please feel free to discuss the issues with your health care providers. If you have questions about this Notice, please call the URMC and Affiliates Integrity Hotline at 585-756-8888 or toll free at 866-567-4202.