



State of Alaska Department of Health and Social Services NOTICE OF USE OF PRIVATE HEALTH CARE INFORMATION

Effective Date April 14, 2003

For Your Protection

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.

Your Health Care Information Is Private

We understand that information we collect about you and your health is personal. Keeping your health care information private is one of our most important responsibilities. We are committed to protecting your health care information and following all laws about its use. You have the right to discuss with the privacy officer your concerns about how your health care information is shared. The law says:

1. We must keep your health care information from others who do not need it.
 2. You may ask us not to share certain health care information. Sometimes, we may not be able to agree to your request.
-

Who Sees And Shares My Health Care Information?

Your health caregivers, such as nurses, doctors, therapists and social workers may see, use and share your health care information to determine your plan of care. This use may cover health care services you had before now or may have later.

We review your health care information and bills (claims) to make sure that you get quality care and that all laws about providing and paying for your health care are being followed. We may also use your information to remind you about appointments or to tell you about treatment alternatives.

How Is Payment Made?

We may share your health care information with health plans, insurance companies, tribal or government programs to help you get your benefits and so that we can be paid or pay for your health care services.

May I See My Health Care Information?

In most cases, you may see your health care information. There may be legal reasons or safety concerns that may limit the amount of information that you may see. You may ask in writing to receive a copy of your health care information. We may charge a small amount for copying costs.

If you think some of your health care information is wrong, you may ask in writing that we correct or add to it. You may ask that the corrected or new information be sent to others who have received your health care information from us. You may ask us for a list of where we sent your health care information.

What If My Health Care Information Needs To Go Somewhere Else?

You may ask to have your health care information sent to others. You will be asked to sign a separate form, called an authorization form, permitting your health care information to go to them.

The authorization form tells us what, where and to whom the information must be sent. You can stop or limit the amount of information sent at any time by letting us know in writing.

Note: If you are younger than 18 years old **and, by law, you are able to give consent for your own health care**, then your health care information is kept private from others unless you sign an authorization form.

Could My Health Care Information Be Released Without My Authorization?

We follow laws that tell us when we have to share health care information, even if you do not sign an authorization form. We always report:

1. contagious diseases, birth defects and cancer;
2. firearm injuries and other trauma events;
3. reactions to problems with medicines or defective medical equipment;
4. to the police when required by law;
5. when the court orders us to;
6. to the government to review how our programs are working;
7. to a provider or insurance company who needs to know if you are enrolled in one of our programs;
8. to Workers Compensation for work related injuries;
9. birth, death and immunization information;
10. to the federal government when they are investigating something important to protect our country, the President and other government workers;
11. abuse, neglect and domestic violence, if related to child protection or vulnerable adults.

We may also share health care information for permitted research purposes, for matters concerning organ donations and for serious threats to public health or safety.

May I Have a Copy of this Notice?

This notice is yours. You may ask for a copy at any time. If there are important changes to this notice, you will get a new one within 60 days if you are enrolled in a health plan, such as Medicaid. An electronic version of this notice is available at www.hss.state.ak.us.

Questions or Complaints?

If you have questions or feel your privacy rights have been violated you can contact the Department Privacy Official by calling 907-465-2150, or by writing to State of Alaska, DHSS Privacy Official, PO Box 110650, Juneau, AK 99811-0650, or by e-mailing PrivacyOfficial@health.state.ak.us.

You can also complain to the federal government Secretary of Health and Human Services (HHS) or to the HHS Office of Civil Rights. **Your health care services will not be affected by any complaint made to the Department Privacy Official, Secretary of Health and Human Services or Office of Civil Rights.**



State of Alaska
Department of Health and Social Services

DHSS Privacy Official
PO Box 110650
Juneau, AK 99811-0650
(907) 465-2150

Health Information Privacy Complaint Form

Name: _____

Home Phone: () _____ Work Phone: () _____

Street Address: _____ City: _____

State: _____ Zip: _____ Email Address (if available): _____

Are you filing this complaint for someone else? [] Yes [] No

If yes, whose health information privacy rights do you believe were violated?

Name: _____

Who (or what agency or organization, e.g., provider, health plan) do you believe violated your (or someone else's) health information privacy rights or committed another violation of the Privacy Rule?

PERSON / AGENCY / ORGANIZATION: _____

Street Address: _____ City: _____

State: _____ Zip: _____ Phone: () _____

When do you believe that the violation of health information privacy rights occurred? _____

Describe briefly what happened. How and why do you believe that your (or someone else's) health information privacy rights were violated, or the privacy rule otherwise was violated? Please be as specific as possible. (Attach additional pages as needed)

Please sign and date this complaint.

Signature _____ Date _____

Filing a complaint with the DHSS is voluntary. However, without the information requested above, DHSS may be unable to proceed with your complaint. We collect this information under authority of the Privacy Rule issued pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). We will use the information you provide to determine if we have jurisdiction and, if so, how we will process your complaint. Information submitted on this form is treated confidentially and is protected under the provisions of the Privacy Act of 1974.

Names or other identifying information about individuals are disclosed when it is necessary for investigation of possible health information privacy violations, for internal systems operations, or for routine uses, which include disclosure of information outside the Department for purposes associated with health information privacy compliance and as permitted by law. It is illegal for the Department of Health and Social Services to intimidate, threaten, coerce, discriminate or retaliate against you for filing this complaint or for taking any other action to enforce your rights under the Privacy Rule. You are not required to use this form. You also may write a letter or submit a complaint electronically with the same information.

(The remaining information on this form is optional. Failure to answer these voluntary questions will not affect DHSS's decision to process your complaint.)

Do you need special accommodations for us to communicate with you about this complaint (please indicate what accommodation is needed)? _____

If we cannot reach you directly, is there someone else we can contact to help us reach you?

If so complete the following:

First Name: _____ Last Name: _____

Home Phone: () _____ Work Phone: () _____

Street Address: _____ City: _____

State: _____ Zip: _____ E-mail Address (if available): _____

Have you filed your complaint anywhere else? If so, please provide the following. (Attach additional pages as needed.)

Date(s) Filed: _____ Case number(s) if known: _____

Questions: If you have questions about this form, you can contact the Department Privacy Official by calling 907-465-2150, or by writing to State of Alaska, DHSS Privacy Official, PO Box 110650, Juneau, AK 99811-0650, or by e-mailing PrivacyOfficial@health.state.ak.us.

In addition to filing a complaint with DHSS, you can also complain to the federal government Secretary of Health and Human Services (HHS) or to the HHS Office of Civil Rights. **Your health care services will not be affected by any complaint made to the Department Privacy Official, Secretary of Health and Human Services or Office of Civil Rights.**