Sunrise Haven

Patient Privacy Information
HIPAA Privacy Notice

At Sunrise Haven, the confidentiality of all information concerning patients is of the utmost importance. The ethical standards upheld by Christian Science nurses and other staff come from the teachings of Christian Science with its emphasis on the confidential relationship between Christian Science nurse and patient, and Christian Science practitioner and patient. Maintaining that confidentiality for your protection is now a Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This law requires that all organizations such as ours protect the privacy of patients in a variety of ways. Sunrise Haven adheres to the letter and spirit of this law. This notice describes how information regarding the services you receive here may be used and disclosed to others. It is effective as of April 14, 2003. Please review it carefully before signing it.

1. I understand that the use or disclosure of my protected health information (PHI) by Sunrise Haven will only be for the purpose of providing Christian Science nursing care to me, obtaining payment for my care bills, and conducting the normal business of running the facility. PHI refers to any information about me and my care needs, collected at Sunrise Haven or from others, deemed necessary to care for me properly. This information about me includes: my name, address, telephone number, and the same information for my spouse or close family member I designate; my date of birth, Social Security and Medicare numbers; my church affiliation, my Christian Science practitioner's name and phone number; any copy of my Health Care Power of Attorney, including the name(s) of my agent(s) and my preferences regarding care; and records regarding my care and billing records.

2. I understand that my health care information will be given to my Responsible Party, the Christian Science practitioner, my insurance company, and Medicare (by law). In addition, I authorize Sunrise Haven to share my health care information with the following individuals:

   a. Name _____ Relationship _____
   b. Name _____ Relationship _____
   c. Name _____ Relationship _____

   If there are more than three individuals who are authorized to receive my health care information, I will ask them to call my Responsible Party.

3. I understand that, if I do not object in writing, Sunrise Haven will share the fact that I am in the facility with telephone callers who directly ask for me by name, and with visitors who arrive and ask for me by name. Sunrise Haven does not, however, disclose information regarding my care or condition in response to these inquiries.

4. I understand that, for my protection, Sunrise Haven will sign agreements with any business associates (for example, its auditor) that would have a valid reason to disclose my PHI. These agreements will include a promise that the business will not disclose any PHI in any way not essential to the normal activities of their business.

5. For my further protection, I understand that I will be asked to sign specific authorization any time Sunrise Haven decides to disclose any of my PHI to other care providers if I am being transferred to an alternate care facility, or to anyone else for purposes other than the routine needs described above. The only exceptions to this would be for contact with legal authorities.

6. I understand Sunrise Haven expects me to bring any concerns about this policy, or Sunrise Haven's compliance with it, to the attention of the Sunrise Haven HIPAA Compliance Officer, Robin Banko. I also have the right to file a formal complaint with the Sunrise Haven HIPAA Compliance Officer and/or with the Federal agency, the Department of Health and Human Services, if I feel that there has been a violation of these privacy rights. Sunrise Haven will not retaliate against me if I feel the need to file a complaint.

7. I understand that I have the right to review the complete Sunrise Haven HIPAA Privacy Policy which is always available at the Business Office. This policy describes the types of uses and disclosures of my PHI that may occur in the course of my stay at Sunrise Haven. I may inspect, copy, or amend my PHI.

_____

Printed name of Patient or POA/Responsible Party

_____

Signature of Patient or POA/Responsible Party

_____

Date