

**Indianola Fire Dept  
Notice of Privacy Practices**

**IMPORTANT: 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.**

Indianola Fire Department is committed to protecting your personal health information. We are required by law to maintain the privacy of health information that could reasonably be used to identify you, known as "protected health information" or "PHI." We are also required by law to provide you with the attached detailed Notice of Privacy Practices ("Notice") explaining our legal duties and privacy practices with respect to your PHI.

We respect your privacy, and treat all health care information about our patients with care under strict policies of confidentiality that all of our staff are committed to following at all times.

PLEASE READ THE ATTACHED DETAILED NOTICE. IF YOU HAVE ANY QUESTIONS ABOUT IT, PLEASE CONTACT Gregory M. Chia, OUR HIPAA COMPLIANCE OFFICER, AT [gchia@cityofindianola.com](mailto:gchia@cityofindianola.com).

**Detailed Notice of Privacy Practices**

**Purpose of This Notice:** This Notice describes your legal rights, advises you of our privacy practices, and lets you know how Indianola Fire Department is permitted to use and disclose PHI about you.

**Uses and Disclosures of Your PHI We Can Make Without Your Authorization**

Indianola Fire Department may use or disclose your PHI without your authorization, or without providing you with an opportunity to object, for the following purposes:

**Uses and Disclosures of PHI:** Indianola Fire Department may use PHI for the purposes of treatment, payment, and health care operations, in most cases without your written permission. Examples of our use of your PHI:

**Treatment.** 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 PHI 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.

**Payment.** This includes any activities we must undertake in order to get reimbursed for the services we provide to you, including such things as organizing your PHI and submitting bills to insurance companies (either directly or through a third party billing company), management of billed claims for services rendered, medical necessity determinations and reviews, utilization review, and collection of outstanding accounts.

**Healthcare Operations.** This includes quality assurance activities, licensing, and training programs to ensure that our personnel meet our standards of care and follow established policies and procedures, obtaining legal and financial services, conducting business planning, processing grievances and complaints, creating reports that do not individually identify you for data collection purposes, fundraising, and certain marketing activities.

**Other Uses and Disclosure of Your PHI We Can Make Without Authorization.**

Indianola Fire Department is also permitted to use or disclose your PHI *without* your written authorization in situations including:

- For the treatment activities of another health care provider;
- To another health care provider or entity for the payment activities of the provider or entity that receives the information (such as your hospital or insurance company);
- To another health care provider (such as the hospital to which you are transported) for the health care operations activities of the entity that receives the information as long as the entity receiving the information has or has had a relationship with you and the PHI pertains to that relationship;
- For health care fraud and abuse detection or for activities related to compliance with the law;
- To a family member, other relative, or close personal friend or other individual involved in your care 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, relatives, or friends if we infer from the circumstances that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when your spouse has called the ambulance for you. In situations where you are not capable of objecting (because you are not present or due to your incapacity or medical emergency), we may, in our professional judgment, determine that a disclosure to your family member, relative, or friend is in your best interest. In that situation, we will disclose only health information relevant to that person's involvement in your care. For example, we may inform the person who accompanied you in the ambulance that you have certain symptoms and we may give that person an update on your vital signs and treatment that is being administered by our ambulance crew;
- To a public health authority in certain situations (such as reporting a birth, death or disease as required by law, as part of a public health investigation, to report child or adult abuse or neglect or domestic violence, to report adverse events such as product defects, or to notify a person about exposure to a possible communicable disease as required by law);
- For health oversight activities including audits or government investigations, inspections, disciplinary proceedings, and other administrative or judicial actions undertaken by the government (or their contractors) by law to oversee the health care system;

- For judicial and administrative proceedings as required by a court or administrative order, or in some cases in response to a subpoena or other legal process;
- For law enforcement activities in limited situations, such as when there is a warrant for the request, or when the information is needed to locate a suspect or stop a crime;
- For military, national defense and security and other special government functions;
- To avert a serious threat to the health and safety of a person or the public at large;
- For workers' compensation purposes, and in compliance with workers' compensation laws;
- To coroners, medical examiners, and funeral directors for identifying a deceased person, determining cause of death, or carrying on their duties as authorized by law;
- 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 organ donation and transplantation;
- For research projects, but this will be subject to strict oversight and approvals and health information will be released only when there is a minimal risk to your privacy and adequate safeguards are in place in accordance with the law.

**Uses and Disclosures of Your PHI That Require Your Written Consent**

Any other use or disclosure of PHI, other than those listed above, will only be made with your written authorization (the authorization must specifically identify the information we seek to use or disclose, as well as when and how we seek to use or disclose it). Specifically, we must obtain your written authorization before using or disclosing your: (a) Psychotherapy notes, other than for the purpose of carrying out our own treatment, payment or health care operations purposes, (b) PHI for marketing when we receive payment to make the marketing communication; or (c) PHI when engaging in a sale of your PHI. **You may revoke your authorization at any time, in writing, except to the extent that we have already used or disclosed medical information in reliance on that authorization.**

**Your Rights Regarding Your PHI**

As a patient, you have a number of rights with respect to the protection of your PHI, including:

**Right to access, copy or inspect your PHI.** You have the right to inspect and copy most of the medical information that we collect and maintain about you. Requests for access to your PHI should be made in writing to our HIPAA Compliance Officer. In limited circumstances, we may deny you access to your medical information, and you may appeal certain types of denials. We have available forms to request access to your PHI, and we will provide a written response if we deny you access and let you know your appeal rights. If you wish to inspect and copy your medical

information, you should contact Gregory M. Chia, our HIPAA Compliance Officer.

We will normally provide you with access to this information within 30 days of your written request. If we maintain your medical information in electronic format, then you have a right to obtain a copy of that information in an electronic format. In addition, if you request that we transmit a copy of your PHI directly to another person, we will do so provided your request is in writing, signed by you (or your representative), and you clearly identify the designated person and where to send the copy of your PHI.

We may also charge you a reasonable cost-based fee for providing you access to your PHI, subject to the limits of applicable state law.

**Right to request an amendment of your PHI.** You have the right to ask us to amend protected health information that we maintain about you. Requests for amendments to your PHI should be made in writing and you should contact Gregory M. Chia, our HIPAA Compliance Officer if you wish to make a request for amendment and fill out an amendment request form.

When required by law to do so, we will amend your information within 60 days of your request and will notify you when we have amended the information. We are permitted by law to deny your request to amend your medical information in certain circumstances, such as when we believe that the information you have asked us to amend is incorrect.

**The right to request an accounting of our use and disclosure of your PHI.** You may request an accounting from us of disclosures of your medical information. If you wish to request an accounting of disclosures of your PHI that are subject to the accounting requirement, you should contact Gregory M. Chia, our HIPAA Compliance Officer and make a request in writing.

You have the right to receive an accounting of certain disclosures of your PHI made within six (6) years immediately preceding your request. But, we are not required to provide you with an accounting of disclosures of your PHI: (a) for purposes of treatment, payment, or healthcare operations; (b) for disclosures that you expressly authorized; (c) for disclosures made for law enforcement or certain other governmental purposes.

**The right to request that we restrict the uses and disclosures of your PHI.** You have the right to request that we restrict how we use and disclose your medical information that we have about you for treatment, payment or health care operations, or to restrict the information that is provided to family, friends and other individuals involved in your health care. However, we are only required to abide by the requested restriction under limited circumstances, and it is generally our policy that we will not agree to any restrictions unless required by law to do so. If you wish to request a restriction on the use or disclosure of your PHI, you should contact Gregory M. Chia, our HIPAA Compliance Officer and make a request in writing.

Indianola Fire Department is required to abide by the requested restriction when you ask that we not release PHI to your health plan (insurer) about a service for which you (or someone on your behalf) have paid Indianola Fire Department in full. We are also required to abide by any restriction that we agree to. Notwithstanding, if you request a restriction that we agree to, and the information you asked us to restrict is needed to provide you with emergency treatment, then we may disclose the PHI to a healthcare provider to provide you with emergency treatment.

A restriction may be terminated if you agree to or request the termination. Most current restrictions may also be terminated by Indianola Fire Department as long as we notify you. If so, PHI that is created or received after the restriction is terminated is no longer subject to the restriction. But, PHI that was restricted prior to the notice to you voiding the restriction must continue to be treated as restricted PHI.

**Right to notice of a breach of unsecured protected health information.**

If we discover that there has been a breach of your unsecured PHI, we will notify you about that breach by first-class mail dispatched to the most recent address that we have on file. If you prefer to be notified about breaches by electronic mail, please contact Gregory M. Chia, our HIPAA Compliance Officer, to make Indianola Fire Department aware of this preference and to provide a valid email address to send the electronic notice. You may withdraw your agreement to receive notice by email at any time by contacting Gregory M. Chia.

**Right to request confidential communications.** You have the right to request that we send your PHI to an alternate location (e.g., somewhere other than your home address) or in a specific manner (e.g., by email rather than regular mail.) However, we will only comply with reasonable requests when required by law to do so. If you wish to request that we communicate PHI to a specific location or in a specific format, you should contact Gregory M. Chia, our HIPAA Compliance Officer and make a request in writing.

**Internet, Email, and the Right to Obtain Copy of Paper Notice** If we maintain a web site, we will prominently post a copy of this Notice on our website and make the Notice available electronically through the web site. If you allow us, we will forward you this Notice by electronic mail instead of on paper and you may always request a paper copy of this notice.

**Revisions to the Notice** Indianola Fire Department is required to abide by the terms of the version of this Notice currently in effect. However, Indianola Fire Department reserves the right to change the terms of this Notice at any time, and the changes will be effective immediately and will apply to all PHI that we maintain. Any material changes to the Notice will be promptly posted in our facilities and on our web site, if we maintain one. You can get a copy of the latest version of this Notice by contacting Gregory M. Chia, our HIPAA Compliance Officer.

**Your Legal Rights and Complaints** You also have the right to complain to us, or to the Secretary of the United States Department of Health and Human Services, if you believe that your privacy rights have been violated. You will not be retaliated against in any way for filing a complaint with us or to the government.

Should you have any questions, comments or complaints, you may direct all inquiries to Gregory M. Chia, our HIPAA Compliance Officer. Individuals will not be retaliated against for filing a complaint.

If you have any questions or if you wish to file a complaint or exercise any rights listed in this Notice, please contact:

Gregory M. Chia  
Indianola Fire Department  
110 North 1<sup>st</sup> Street  
PO Box 299  
Indianola, Iowa 50125  
[gchia@cityofindianola.com](mailto:gchia@cityofindianola.com)

**Effective Date of this Notice:** 9/23/2013

# Indianola Fire Department

## Refusal of Emergency Services/Payment Responsibility/ Privacy Policy and Liability Release Form

Incident Number: \_\_\_\_\_

Incident Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Name: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone Number: ( ) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ Apt: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### Refusal of Emergency Services and Liability Release

I, \_\_\_\_\_, do hereby:

(Print patient's or designated decision maker's name)

\_\_\_\_\_ Against Medical Advice, refuse medical care, transportation, and/or advice by the City of Indianola Fire Department or its agents.

\_\_\_\_\_ Refuse Specific care, advice, or recommended destination as provided by the City of Indianola Fire Department or its agents.

\_\_\_\_\_ Report of No Injuries or Medical Problem, to the City of Indianola Fire Department or its agents. Because I do not have any specific complaint of any injury or medical problem, I do not want to be assessed, treated, or transported to a hospital by the City of Indianola Fire Department. I understand I have not been fully assessed by an emergency medical care provider or a physician.

Time	:
Blood Pressure	/
Heart Rate	BPM
Respiratory Rate	/min.
Lung Sounds	
Pulse Oximetry	SpO2 %
Blood Sugar	mg/dl

I acknowledge that I have read and understand the terms of this release and I have signed this voluntarily. I hereby release and hold harmless the City of Indianola, its officials, employees, agents, and, if a hospital was contacted, the hospital and its representatives from any and all further responsibility for medical care, transportation, destination, advice, or any other form of assistance. I agree that this release shall be binding on my relatives, heirs, legal representatives and assigns.

		Indianola Fire Department Signatures	
_____	____/____/____	_____	____/____/____
Patient signature or mark	Date	Crew member signature	Date
_____	____/____/____	_____	____/____/____
Signature of designated decision maker	Date	2 <sup>nd</sup> crew member signature	Date
_____	____/____/____		
Signature of witness	Date		

### Privacy Policy and Signature

I request that a payment of authorized Medicare, Medicaid, or any other insurance benefits be made on my behalf to the City of Indianola Fire Department and its affiliates for any services provided to me by the City of Indianola Fire Department now or in the future. I understand that I am financially responsible for the services provided to me by the City of Indianola Fire Department, regardless of my insurance coverage, and in some cases, may be responsible for an amount in addition to that which was paid by my insurance. Our collections process consists of withholding state of Iowa income tax refunds or payments if payments on ambulance bills are not made. I agree to immediately remit to the City of Indianola Fire Department any payments 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 the City of Indianola Fire Department. I authorize the City of Indianola Fire Department 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 the City of Indianola Fire Department and its billing agents, and/or the Centers for Medicare and Medicaid Services and its carriers and agents, and/or any other payers or insurers as may be necessary to determine these or other benefits payable for any services provided to me by City of Indianola Fire Department, now or in the future. A copy of this form is as valid as an original.

**Privacy Practices Acknowledgment:** By signing below, I acknowledge that I have received the City of Indianola Notice of Privacy Practices.

Section I – Patient Signature	Section II – Authorized representative signature
The patient must sign here unless the patient is physically or mentally incapable of signing.	Complete this section <u>only</u> if patient is physically or mentally incapable of signing. Reason the patient is physically or mentally incapable of signing:
<input checked="" type="checkbox"/> _____ Patient signature or mark Date	_____
<input type="checkbox"/> Patient refused to sign	Authorized representatives include <u>only</u> the following individuals (check one):
<b>IFD Patient Care Provider:</b>	<input type="checkbox"/> Patients Legal Guardian
_____	<input type="checkbox"/> Patients Health Care Power of Attorney
Crew member signature Date	<input type="checkbox"/> Relative or other person who receives government benefits on behalf of patient
_____	<input type="checkbox"/> Relative or other person who arranges treatment or handles the patient's affairs
Crew member printed name Date	<input type="checkbox"/> Representative of an agency or institution that furnished care, services or assistance to the patient
<i>Note: if patient is a minor, the parent or legal guardian MUST sign in this section.</i>	<i>I am signing on behalf of the patient. I recognize that signing on behalf of the patient is not an acceptance of financial responsibility for the services rendered.</i>
	_____
	Representative Signature Date Printed Name of Representative

### Section III – Emergencies Only – Paramedic Crew and Facility Representative Signatures

Complete this section only if all of the following are true: (1) the call is an emergency ambulance transport, (2) the patient was physically or mentally incapable of signing, and (3) no authorized representative (Section II) was available or willing to sign on behalf of the patient at time of service.

#### 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 named above was physically or mentally incapable of signing, and that none of the authorized representatives listed in Section II of this form were willing to sign on the patient's behalf. My signature is not an acceptance of financial responsibility for the services rendered.

Reason patient incapable of signing: \_\_\_\_\_

Name and location of receiving facility: \_\_\_\_\_

Time at receiving facility: \_\_\_\_:\_\_\_\_

\_\_\_\_\_  
Signature of Crew Member Date Printed Name of Crew Member

#### 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 Date Printed Name and Title of Receiving Facility Representative

**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. Effective 09/23/2014**

**Purpose of this notice:** The City of Indianola Fire Department is required by law to maintain the privacy of certain confidential health care information, known as Protected Health Information or PHI, and to provide you with a notice of our legal duties and privacy practices with respect to your PHI. The City of Indianola Fire Department is also required to abide by the terms of the version of this Notice currently in effect.

**Uses and Disclosures of PHI:** The City of Indianola Fire Department may use PHI for the purposes of treatment, payment, and health care operations, in most cases without your written permission. Examples of our use of your PHI:

**For treatment.** This includes such things as obtaining verbal and written information about your medical condition and treatment from you as well as from others, such as doctors and nurses who give orders to allow us to provide treatment to you. We may give your PHI to other health care providers involved in your treatment, and may transfer your PHI via radios or telephone to the hospital or dispatch center.

**For payment.** This includes any activities we must undertake in order to get reimbursed for the services we provide to you, including such things as submitting bills to insurance companies, making medical necessity determinations and collecting outstanding accounts.

**For healthcare operations.** This includes quality assurance activities, licensing, and training programs to ensure that our personnel meet our standards of care and follow established policies and procedures, as well as certain other management functions.

**Uses and Disclosures of PHI Without Your Authorization.**

- The City of Indianola Fire Department is permitted to use PHI *without* your written authorization, or opportunity to object, in certain situations, and unless prohibited by a more stringent state law, including:
- For the treatment, payment or health care operations activities or another health care provider who treats you;
- For health care and legal compliance activities;
- To a public health authority in certain situations as required by law (such as to report abuse, neglect or domestic violence);
- For health oversight activities including audits or government investigations, inspections, disciplinary proceedings, and other administrative or judicial actions undertaken by the government (or their contractors) by law to oversee the health care system;
- For judicial and administrative proceedings as required by a court or administrative order, or in some cases in response to a subpoena or other legal process;
- For law enforcement activities in limited situations, such as when responding to a warrant;
- For military, national defense and security and other special government functions;
- To avert a serious threat to the health and safety of a person or the public at large;
- For workers' compensation purposes, and in compliance with workers' compensation laws;
- To coroners, medical examiners, and funeral directors for identifying a deceased person, determining cause of death, or carrying on their duties as authorized by law;
- 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 organ donation and transplantation;
- For research projects, but this will be subject to strict oversight by a family member, other relative, or close personal friend or other individual involved in your care 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, and in certain other circumstances where we are unable to obtain your agreement and believe the disclosure is in your best interest.
- We may also use or disclose health information about you in a way that does not personally identify you or reveal who you are. Any other use or disclosure of PHI, other than those listed above only will be made with your written authorization. (The authorization must specifically identify the information we seek to use or disclose, as well as when and how we seek to use or disclose it) **You may revoke your authorization at any time, in writing, except to the extent that we have already used or disclosed medical information in reliance on that authorization.**

**Patient Rights:** As a patient, you have a number of rights with respect to your PHI, including:

**The right to access, copy, or inspect your PHI.**

This means you may inspect and copy most of the medical information about you that we maintain. We will normally provide you with access to this information within 30 days of your request. We may also charge you a reasonable fee for you to copy any medical information that you have the right to access. In limited circumstances, we may deny you access to your medical information, and you may appeal certain types of denials. We have available forms to request access to your PHI and we will provide a written response if we deny you access and let you know your appeal rights. You also have the right to receive confidential communications of your PHI. If you wish to inspect and copy your medical information, you should contact our privacy officer.

**The right to amend your PHI.** You have the right to ask us to amend written medical information that we may have about you. We will generally amend your information within 60 days of your request and will notify you when we have amended the information. We are permitted by law to deny your request to amend your medical information only in certain circumstances, like when we believe the information you have asked us to amend is correct. If you wish to request that we amend the medical information that we have about you, you should contact our privacy officer.

**The right to request an accounting.** You may request an accounting from us of certain disclosures of your medical information that we have made in the six years prior to the date of your request. We are not required to give you an accounting of information we have used or disclosed for purposes of treatment, payment or health care operations, or when we share your health information with our business associates, like our billing company or a medical facility from/to which we have transported you. We are also not required to give you an accounting of our uses of protected health information for which you have already given us written authorization. If you wish to request an accounting, contact our privacy officer.

**The right to request that we restrict the uses and disclosures of your PHI.** You have the right to request that we restrict how we use and disclose your medical information that we have about you. The City of Indianola Fire Department is not required to agree to any restrictions you request, but any restrictions agreed to by the City of Indianola Fire Department in writing are binding on the City of Indianola Fire Department. The City of Indianola Fire Department is required to abide by a requested restriction when you ask that we not release PHI to your health plan (insurer) about a service for which you (or someone on your behalf) have paid the City of Indianola Fire Department in full.

**Internet, Electronic Mail, and the Right to Obtain Copy of Paper Notice on Request.** If we maintain a web site, we will prominently post a copy of this Notice on our web site. If you allow us, we will forward you this Notice by electronic mail instead of on paper and you may always request a paper copy of the Notice.

**Revisions to the Notice:** The City of Indianola Fire Department reserves the right to change the terms of this Notice at any time, and the changes will be effective immediately and will apply to all protected health information that we maintain. Any material changes to the notice will be promptly posted in our facilities and posted on our web site, if we maintain one. You can get a copy of the latest version of this Notice by contacting our privacy officer.

**Your Legal Rights and Complaints:** You also have the right to complain to us, or to the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against in any way for filing a complaint with us or to another branch of the government. Should you have any questions, comments or complaints you may direct all inquiries to our privacy officer.

**Privacy Officer Contact Information:**

Privacy Officer, City of Indianola Fire Department, Indianola, IA 50125.

Office: (515) 961-9405, Fax: (515) 962-5003