

**Your Information.  
Your Rights.  
Our Responsibilities.**



**George Street Center**  
116 S. George Street  
York, PA 17401  
717-845-8617  
[www.FamilyFirstHealth.org](http://www.FamilyFirstHealth.org)

This **NOTICE OF PRIVACY PRACTICES** 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 Rights:**

<b>When it comes to your health information, you have certain rights.</b> This section explains your rights and some of our responsibilities to help you.	
<b>Get an electronic or paper copy of your medical record</b>	<ul style="list-style-type: none"> <li>You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.</li> <li>We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.</li> </ul>
<b>Ask us to correct your medical record</b>	<ul style="list-style-type: none"> <li>You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.</li> <li>We may say "no" to your request, but we'll tell you why in writing within 60 days.</li> </ul>
<b>Request confidential communications</b>	<ul style="list-style-type: none"> <li>You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.</li> <li>We will say "yes" to all reasonable requests.</li> </ul>
<b>Ask us to limit what we use or share</b>	<ul style="list-style-type: none"> <li>You can ask us not to use or share certain health information for treatment, payment, or our operations.</li> <li>We are not required to agree to your request, and we may say "no" if it would affect your care.</li> <li>If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information with your health insurer.</li> <li>We will say "yes" unless a law requires us to share that information</li> </ul>
<b>Get a list of those with whom we've shared information</b>	<ul style="list-style-type: none"> <li>You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.</li> <li>We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.</li> </ul>
<b>Get a copy of this privacy notice</b>	<ul style="list-style-type: none"> <li>You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically.</li> </ul>
<b>Choose someone to act for you</b>	<ul style="list-style-type: none"> <li>If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.</li> <li>We will make sure the person has this authority and can act for you before we take any action.</li> </ul>

<p><b>File a complaint if you feel your rights are violated</b></p>	<ul style="list-style-type: none"> <li>You can file a complaint if you feel we have violated your rights by contacting us using the information at the top of this notice.</li> <li>You can file a complaint with the US. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, SW Washington, D.C. 20201, calling 1-877-696-6775, or visiting <a href="http://www.hhs.gov/ocr/privacy/hipaa/complaints/">www.hhs.gov/ocr/privacy/hipaa/complaints/</a></li> <li>We will not retaliate against you for filing a complaint.</li> </ul>
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## Your Choices:

<p><b>For certain health information, you can tell us your choices about what we share.</b> If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instruction.</p>	
<p><b>In these cases, you have both the right and choice to tell us to:</b></p>	<ul style="list-style-type: none"> <li>Share information with your family, close friends, or others involved in your care</li> <li>Share information in a disaster relief situation</li> <li>Include your information in a hospital directory</li> <li>Contact you for fundraising efforts</li> </ul> <p><i>If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.</i></p>
<p><b>In these cases, we never share your information unless you give us written permission:</b></p>	<ul style="list-style-type: none"> <li>Marketing purposes</li> <li>Sale of your information</li> <li>Most sharing of psychotherapy notes</li> </ul>
<p><b>In the case of fundraising:</b></p>	<ul style="list-style-type: none"> <li>We may contact you for fundraising efforts, but you can tell us not to contact you again.</li> </ul>
<p><b>If you are paying out-of-pocket for services:</b></p>	<ul style="list-style-type: none"> <li>You may request that the organization does not disclose your protected health information related to that service, as long as the disclosure is not otherwise required by law.</li> </ul>

## Our Uses and Disclosures:

<p><b>How do we typically use or share your health information?</b></p>		
<p><b>Treat you</b></p>	<ul style="list-style-type: none"> <li>We can use your information and share it with other professionals who are treating you.</li> </ul>	<p><b>Example:</b> A doctor treating you for an injury asks another doctor about your overall health condition.</p>
<p><b>Run our organization</b></p>	<ul style="list-style-type: none"> <li>We can use and share your health information to run our practice, improve our care, and contact you when necessary.</li> </ul>	<p><b>Example:</b> We use health information about you to manage your treatment and services.</p>
<p><b>Bill for your services</b></p>	<ul style="list-style-type: none"> <li>We can use and share your health information to bill and get payment from health plans or other entities.</li> </ul>	<p><b>Example:</b> We give information about you to your health insurance plan so it will pay for your services.</p>

**How else can we use or share your health information?** We are allowed to or required to share your information in other ways - usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes, summarized on the next page:

<b>Help with public health and safety issues</b>	<ul style="list-style-type: none"> <li>• We can share health information about you for certain situations such as: <ul style="list-style-type: none"> <li>⇒ Preventing disease</li> <li>⇒ Helping with product recalls</li> <li>⇒ Reporting adverse reactions to medications</li> <li>⇒ Reporting suspected abuse, neglect, or domestic violence</li> <li>⇒ Preventing or reducing a serious threat to anyone's health or safety</li> </ul> </li> </ul>
<b>Do research</b>	<ul style="list-style-type: none"> <li>• We can use or share your information for health research.</li> <li>• The disclosure of genetic information for underwriting purposes is prohibited.</li> </ul>
<b>Health Information Exchanges</b>	<ul style="list-style-type: none"> <li>• We participate in initiatives to facilitate electronic health information sharing, including but not limited to Health Information Exchanges (HIEs). An HIE is an organization that enables coordinated information sharing among members for the purposes of treatment continuity (such as follow up after hospitalization), avoiding duplication of services (such as tests), and reducing the likelihood that medical or payment errors will occur.</li> <li>• All participants of HIEs agree to a set of standards relating to the use and disclosure of health information, intended to comply with all applicable state and federal laws.</li> <li>• Patients may opt-out of some of these electronic sharing initiatives. We will use reasonable efforts to limit the sharing of PHI in electronic sharing initiatives for patients who have opted-out. If you wish to opt-out, or have questions related to HIEs, please contact our office and ask to speak with our Privacy Officer.</li> </ul>
<b>Comply with the law</b>	<ul style="list-style-type: none"> <li>• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.</li> </ul>
<b>Respond to organ and tissue donation requests</b>	<ul style="list-style-type: none"> <li>• We can share health information about you with organ procurement organizations.</li> </ul>
<b>Work with a medical examiner or funeral director</b>	<ul style="list-style-type: none"> <li>• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.</li> </ul>
<b>Address workers' compensation, law enforcement, and other government requests</b>	<ul style="list-style-type: none"> <li>• We can use or share health information about you: <ul style="list-style-type: none"> <li>⇒ For workers' compensation claims</li> <li>⇒ For law enforcement purposes or with a law enforcement</li> <li>⇒ With health oversight agencies for activities authorized by law</li> <li>⇒ For special government functions such as military, national security, and presidential protective services</li> </ul> </li> </ul>
<b>Respond to lawsuits and legal actions</b>	<ul style="list-style-type: none"> <li>• We can share health information about you in response to a court or administrative order, or in response to a subpoena</li> </ul>

For more information see: <https://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html>

### Our Responsibilities:

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- Uses and disclosures not described in this notice will only be made with prior authorization from you.
- We must follow the duties and privacy practices described in this notice and give you a copy of it
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

### Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

### This Notice of Privacy Practice applies to all sites and services of Family First Health:

<b>Columbia Center</b>	369 Locust St, Columbia PA 17512	717-342-2577	Includes Medical and Community Health Programs
<b>Columbia Dental</b>	430 Walnut St, Suite 101, Columbia, PA 17512	717-356-2233	Includes Dental and Community Health Programs
<b>George Street Center</b>	116 S. George St, York PA 17401	717-845-8617	Includes Medical, Dental, and Community Health Programs
<b>Gettysburg Center</b>	1275 York Rd, Suite 17, Gettysburg PA 17325	717-337-9400	Includes Medical, Dental, and Community Health Programs
<b>Hannah Penn Center</b>	415 E. Boundary Ave, Suite 101, York PA 17403	717-843-5174	Includes Medical and Community Health Programs
<b>Hanover Center</b>	1230 High St, Hanover PA 17331	717-632-9052	Includes Medical, Dental, and Community Health Programs
<b>Lebanon Center</b>	300 Willow St, Entrance B, Lebanon PA 17046	717-356-2222	Includes Medical and Community Health Programs
<b>Lewisberry Center</b>	308 Market St, Lewisberry PA 17339	717-938-6695	Includes Medical and Community Health Programs

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## ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been provided a copy of Family First Health's Notice of Privacy Practices.

Signature of Patient or Personal Representative:	Date:
Printed Name of Patient or Personal Representative:	Date: