THE MADISON CENTER
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY TO YOU

The Madison Center takes the privacy of your health information seriously. We are required by applicable federal and state law to:

- maintain the privacy of your health information
- give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information; and
- follow the privacy practices that are described in this Notice while it is in effect.

This Notice takes effect July 5, 2004, our first day of business, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, to the extent permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

- **Treatment**: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. For example, we will share your speech therapy treatment plan and results with your referring physician or we may share information on the impact of your general health on your speech therapy.
- **Payment**: We may use and disclose your health information to obtain payment for services we provide to you from an insurance company or a third party. This may include providing information to your health plan or insurance company before it approves or pays for healthcare services that we recommend. For example, we may tell your health plan about recommended services to determine whether your plan will cover the services. We may also disclose medical information to other healthcare providers for their payment purposes.
- **Healthcare Operations**: We may use and disclose your health information in connection with our healthcare operations. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.
- **Your Authorization**: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.
- **To Your Family and Friends**: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.
- **Persons Involved in Care**: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an

opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare.

- **Marketing Health-Related Services**: We will not use your health information for marketing communications without your written authorization.
- **Treatment Alternatives.** We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.
- **Health-Related Benefits and Services.** We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.
- **Fundraising Activities.** We may use medical information about you to contact you in an effort to raise money for The Madison Center and its operations. If you do not want to be contacted for fundraising efforts, you must notify our Privacy Officer in writing.
- **Required by Law**: We may use or disclose your health information when we are required to do so by law.
- **Abuse or Neglect**: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
- **National Security**: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.
- **Appointment Reminders**: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, e-mails or letters).

YOUR PATIENT RIGHTS

- **Access**: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. (You must make a request in writing to obtain access to your health information.) We will charge you a reasonable cost-based fee for expenses such as copies and staff time.
- **Disclosure Accounting**: You have the right to receive an accounting of certain disclosures that were made after April 14, 2003 of your protected health information for purposes other than treatment, payment, and certain other activities. This does not include uses and disclosures for which you gave us written authorization.
- **Restriction**: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).
- **Alternative Communication**: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.
- **Amendment**: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstance.

YOUR QUESTIONS AND COMPLAINTS

Please contact us if you want more information about our privacy practices or if you have any questions or concerns. If you believe that we have violated your privacy rights, or you disagree with a decision we made regarding your health information, you may complain to us using the contact information listed at the end of this Notice. All complaints must be submitted in writing. You also may submit a written complaint to the U.S. Department of Health and Human Services. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Privacy Officer: Tracy Dolliff, Director/Administrator
Telephone: (952) 401-4242
Fax: (952) 401-4285
E-mail: tacarr@aol.com
Address: 464 2nd Street, Suite 105
Excelsior, MN 55331

THE MADISON CENTER ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Patient's Name	Date of Birth	Parent, Guardian or Authorized Agent's Name
	/ /	

I acknowledge that I have received a written copy of The Madison Center **Notice of Privacy Practices.** I also acknowledge that I have been allowed to ask questions concerning this notice and my rights under this notice. I understand that this form will be a part of my record until such time as I may choose to revoke this acknowledgment. If I am not the patient, I represent that I am authorized by law to act for and on the patient's behalf.

____ ______________________
Signature of Patient, Parent, Guardian or Authorized Agent Date

****

TO BE COMPLETED BY THE MADISON CENTER IF NO ACKNOWLEGMENT CAN BE OBTAINED:

Good faith efforts were made to obtain acknowledgment from the patient or patient's authorized agent. The good faith efforts made, and the reason acknowledgment could not be obtained, were:

Patient (or authorized agent) refused to sign after being requested to do so.

Minor presented without parent or authorized agent. NPP, acknowledgement form, and self-addressed envelope sent home with patient.

Other: (Please describe):

____

____

Completed by ___________________________, Title __________________, Date ________________

STPL-Word:33398.1