Dear Parent/ Legal Guardian,

The high school your student is enrolled in provides expanded medical services, such as care for acute illnesses, primary prevention and emergency health care, and treatment for chronic conditions. The goal of the program is to improve the overall health status of students through shared school-based and community resources helping to assure that students are healthy in the classroom and ready to learn.

The School-Based Health Clinics Program is a partnership between the Florida Department of Health in Pinellas County, Juvenile Welfare Board (JWB), Pinellas County School System, Suncoast Center, Inc., and the administrations at Boca Ciega, Gibbs, Northeast, Largo and Pinellas Park High School.

The expanded services are funded by JWB through local taxes. As part of the funding, the Florida Department of Health in Pinellas County is required to collect personally identifiable information on students for program accountability and quality improvement activities.

This packet of material contains information on the program as well as forms for enrolling your student in the clinic.

If you would like your student to receive additional health services **AT NO COST**, please complete and sign the following forms and return them to the school clinic as soon as possible:

Consent for School-Based Health Clinic Services – complete the entire form and sign *Section 3* and, if your student has Medicaid, check the box in *Section 4* and sign the bottom.

Adolescent Health History – complete the entire form.

Initiation of Services – complete and sign *Part VII.*

Interagency Consent for Services and Release of Information – complete and sign.

Notice of Privacy Practices – keep for your records.

If you have any questions about these forms or services, please contact the clinic at your child's school:

Boca Ciega High School Clinic: (727) 893-2780 ext. 2026
Gibbs High School Clinic: (727) 893-5452 ext. 2026
Largo High School Clinic: (727) 588-3758 ext. 2026
Northeast High School Clinic: (727) 570-3138 ext. 2325
Pinellas Park High School Clinic: (727) 538-7410 ext. 2026

FLORIDA DEPARTMENT OF HEALTH

Consent for School-Based Health Clinic Services

1. Student information (please print clearly)

Last Name: _____ Date of Birth: _____

First Name: _____ School: _____

Middle Name: _____ Grade Attending: _____

Suffix: _____ Social Security #: _____

2. Services Available to High School Students at NO Cost:

Please check any services we **cannot** provide to your child.

- ☐ School/Sports Physicals
- ☐ Immunizations
- ☐ Lab Tests (e.g. throat, urine cultures)
- ☐ Care For Minor Illness & Injuries
- ☐ Administer Over the Counter Medications (e.g. Tylenol, Ibuprofen, Tums)
- ☐ Social, Emotional, and Mental Health Counseling

Comments:

3. Agreement for Student Services

Please read carefully and sign:

I do hereby give my consent for the above named student to receive services at the Florida Department of Health School-Based Clinic. All services listed above that have not been checked will be available to my child. I further understand that all services authorized by myself will be available at no cost.

Please check one: ☐ **Parent** ☐ **Legal Guardian** ☐ **Student (if 18 or older)**

Print Name: _____ Signature: _____ Date: _____

The Following Questions are for Data Gathering Purposes Only

1. Is your child covered by Private Insurance? ☐ Yes ☐ No
2. Is your child covered by Healthy Kids? ☐ Yes ☐ No
3. I am aware of Florida Kid Care program and I know how to apply for it. ☐ Yes ☐ No*

*If you answered **no** to question #3, contact Florida KidCare at 1-888-540-5437 Monday – Friday, 7:30 am – 7:30 pm (ET).

4. Medicaid Coverage Consent

Is your child covered by Medicaid? ☐ Yes ☐ No (If Yes, please continue. If No, please skip the rest of Section 4 below.)

State of Florida Consent for Billing Medicaid

Although all school-based clinic services are available at no cost to you, the Florida Department of Health does receive partial financial assistance by billing Medicaid for students with Medicaid coverage. If your child is indeed covered by Medicaid, please sign the following consent.

I hereby assign the Florida Department of Health all benefits provided under the Medicaid health care plan. The amount of such benefits shall not exceed the medical charges set forth by the Pinellas County Board of Commissioners. All payments under this paragraph are to be made to the Florida Department of Health. I further authorize the Florida Department of Health at 205 Dr. M. L. King Jr. Street North, St. Petersburg, FL 33701 and any physician or healthcare provider examining or treating my child to release to any third party for any medical, psychiatric/psychological, alcohol/drug abuse, sexually transmitted disease, tuberculosis, AIDS, HIV, abuse or case management information including information received from other health care providers, concerning diagnosis and treatment for its use in determining a claim for such diagnosis or treatment. This may include any and all information pertaining to payment.

Please check one: ☐ **Parent** ☐ **Legal Guardian** ☐ **Student (if 18 or older)**

Print Name: _____ Signature: _____ Date: _____

Adolescent Health History
Confidential

Name: _____ _____ _____ **Date:** _____
Last First Middle

Date of Birth: ____/____/____ **Sex:** ☐ Male ☐ Female **Age:** _____ **Race:** _____ **Gender:** _____

Ethnicity: ☐ Hispanic, Latino, or Spanish Origin: _____ **Twin:** ☐ Yes ☐ No

☐ Non-Hispanic

Primary language spoken: _____

Number of Minor Children (under 18): _____

Number of Adults (18 or older): _____

Annual Household income (before taxes): _____

Household Arrangement (select one):
___ Single Parent-Mother Head of household
___ Single Parent-Father Head of household
___ Dual Parent (both parents)-Married
___ Dual Parent-Non-Married Father/Mother
___ Other _____

Medical History

Does your Child have Established Primary Care? Y N	Does your child have allergies?
Name of Personal/ Family Physician:	Allergic Reaction(s):
Date of last visit with Physician: Last Physical:	Does your child carry epi pen or inhaler? Y N
Does your child have a Dentist? Y N	Is your child taking any Medication? Y N Please list:
Date of last dental exam:	

Please answer all questions below, for responses with yes include any additional information and indicate the age it was diagnosed:

	Yes	No	Age		Yes	No	Age		Yes	No	Age
ADHD	☐	☐		Mononucleosis	☐	☐		Victim of physical or sexual abuse	☐	☐	
Anemia or bleeding disorders	☐	☐		Nosebleeds	☐	☐		**Family History:**			Relationship
Asthma	☐	☐		Pneumonia	☐	☐		ADHD	☐	☐	
Autism spectrum	☐	☐		Prediabetes	☐	☐		Asthma	☐	☐	
Dental problems/cavities	☐	☐		Premature birth	☐	☐		Cancer	☐	☐	
Diabetes Type 1 or 2	☐	☐		Scoliosis/orthopedic problems	☐	☐		Depression	☐	☐	
Eating disorder or concerns	☐	☐		Seizures	☐	☐		Diabetes	☐	☐	
Fainting spells	☐	☐		Severe acne/skin problem	☐	☐		Heart Disease	☐	☐	
Headaches	☐	☐		Severe menstrual cramps	☐	☐		High Blood Pressure	☐	☐	
High blood pressure or heart disease	☐	☐		Sickle cell disease	☐	☐		High Cholesterol	☐	☐	
High cholesterol	☐	☐		Single kidney	☐	☐		Kidney Disease	☐	☐	
Hospitalizations	☐	☐		School academic or social concerns	☐	☐		Does anyone smoke in the house?	☐	☐	
Kidney or bladder problems	☐	☐		Snoring or sleep problem	☐	☐		If either biological parent is deceased if yes, cause:	☐	☐	
Menstrual irregularities	☐	☐		Stomach problems	☐	☐		Other:	☐	☐	
Mental Health	☐	☐		Surgeries	☐	☐		Other:	☐	☐	
Migraines/headaches	☐	☐		Testes	☐	☐		Other:	☐	☐	

If yes, please describe:

INITIATION OF SERVICES

PART I. **CLIENT – PROVIDER RELATIONSHIP CONSENT**

Client Name: _____

Name of Agency: **Florida Department of Health- Pinellas County**

Agency Address: **205 Dr. Martin Luther King Jr. St. N., St. Petersburg, FL 33701**

I consent to entering into a client-provider relationship. I authorize Department of Health staff and their representative to render routine health care. I understand routine health care is confidential and voluntary and may involve medical office visits including obtaining medical history, examination, administration of medication, laboratory test and/or minor procedures. I may discontinue this relationship at any time.

PART II. **DISCLOSURE OF INFORMATION CONSENT (**treatment, payment or healthcare operations purposes only)

I consent to the use and disclosure of my medical information; including medical, dental, HIV/AIDS, STD, TB, substance abuse prevention, psychiatric/psychological, and case management; for treatment, payment and healthcare operations.

PART III. **COMMUNICATIONS**

I understand the Florida Department of Health (DOH) uses a patient portal to communicate with me about my healthcare. In order to receive electronic communications about my health care. I need to provide my email address to the department and then I will be contacted by email to create a portal account.

I understand that I must agree to the terms and conditions of use associated with the portal when I create my account. I understand that the portal is password protected and that I am responsible for maintaining the confidentiality of my user name and password and for all activities that are conducted through my portal account. I understand that I will receive emails letting me know that DOH has sent information to the portal.

____Initial here to authorize and give my express consent to the DOH to make your health care information available to you through the portal.

Email Address: _____.I understand that I have a right to stop participation in the portal at any time by either removing my email address or closing my portal account.

____Initial here to remove your email address from the DOH system and stop receiving information through the portal.

PART IV. **MEDICARE PATIENT CERTIFICATION, AUTHORIZATION TO RELEASE, AND PAYMENT REQUEST** (Only applies to Medicare Clients)

As Client/Representative signed below. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the above agency to release my medical information to the Social Security Administration or its intermediaries/carriers for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician's services to the above named agency and authorize it to submit a claim to Medicare for payment.

PART V. **ASSIGNMENT OF BENEFITS** (Only applies to Third Party Payers)

As client/Representative signed below. I assigned to the above named agency all benefits provided under any health care plan or medical expense policy. The amount of such benefits shall not exceed the medical charges set forth by the approved fee schedule. All payments under this paragraph are to be made to above agency. I am personally responsible for charges not covered by this assignment.

PART VI. **COLLECTION, USE OR RELEASE OF SOCIAL SECURITY NUMBER** (This notice is provided pursuant to section 119.071(5) (a). Florida Statutes.)

For health care programs the Florida Department of Health may collect your social security number for identification and billing purposes, as authorized by subsections 119.071 (5)(a)2.a. and 119.071(5)(a)6., Florida Statutes. By signing below, I consent to the collection, use or disclosure of my social security number for identification and billing purposes only. It will not be used for any other purpose. I understand that the collection of social security numbers by the Florida Department of Health is imperative for the performance of duties and responsibilities as prescribed by law.

PART VII. **MY SIGNATURE BELOW VERIFIES THE ABOVE INFORMATION AND RECEIPT OF THE NOTICE OF PRIVACY RIGHTS**

_____ _____ _____

Client/Representative Signature. Self or Representative's Relationship to Client Date

_____ _____

Witness (optional) Date

PART VIII. **WITHDRAWAL OF CONSENT**

I _____ WITHDRAW THIS CONSENT. Effective_____

Client/Representative Signature Date

_____ _____

Witness (optional) Date

Client Name: _____

ID#:_____

DOB: _____

Original to file; Copy to client

DH8001-IT-01/2017

INICIO DE SERVICIOS

PARTES. **CONSENTIMIENTO DE LA RELACIÓN CLIENTE-PROVEEDOR**

Nombre del cliente; _____

Nombre de la agencia: **Florida Department of Health- Pinellas County**

Dirección de la agencia: **205 Dr. Martin Luther King Jr. St. N., St. Petersburg, FL 33701**

Doy mi consentimiento para comenzar una relación entre el cliente y el proveedor. Autorizo al Departamento de Salud y sus representantes a proveer servicios de atención de la salud de rutina. Entiendo que la atención de la salud de rutina es confidencial y voluntaria y podría suponer visitas a consultorios clínicos, lo que incluye obtener mi historia clínica, exámenes, la administración de medicamentos, pruebas de laboratorio o procedimientos menores. Puedo discontinuar la relación en cualquier momento.

PARTE II. **CONSENTIMIENTO A LA DIVULGACIÓN DE INFORMACIÓN** (solo para fines de operaciones de tratamiento, pago o atención de la salud)

Autorizo a que se utilice y divulgue mi información médica, que incluye registros dentales, información sobre VIH/SIDA, ETS, TB, prevención del abuso de sustancias, información psiquiátrica/psicológica y administración del caso, para operaciones de tratamiento, pago y atención de la salud.

PARTE III. **COMUNICACIONES**

Entiendo que el Departamento de Salud (DOH) de Florida utiliza un portal de los pacientes para comunicarse conmigo sobre la atención de mi salud. Para recibir comunicaciones electrónicas sobre la atención de mi salud, debo brindarle mi dirección de correo electrónico al departamento, y luego me contactarán por correo electrónico para que cree una cuenta en el portal.
Entiendo que debo aceptar los términos y condiciones de uso asociados con el portal cuando cree mi cuenta. Entiendo que el portal está protegido con contraseña y que soy responsable de mantener la confidencialidad de mi nombre de usuario y contraseña, y de todas las actividades que se realicen a través de mi cuenta en el portal. Entiendo que recibiré correos electrónicos que me avisarán que el DOH ha enviado información al portal.
_____Coloque sus iniciales aquí para autorizar y dar su consentimiento expreso al DOH para que ponga su información médica a su disposición mediante el portal.
Dirección de correo electrónico: _____
Entiendo que tengo el derecho de detener la participación en el portal en cualquier momento, ya sea eliminando mi dirección correo electrónico o cerrando mi cuenta en el portal.

_____Coloque sus iniciales aquí para eliminar su dirección de correo electrónico del sistema del DOH y dejar de recibir información por el portal.

PARTE IV. **CERTIFICACIÓN DEL PACIENTE, AUTORIZACIÓN PARA DIVULGAR Y SOLICITUD DE PAGO DE MEDICARE** (Solamente aplica a Clientes de Medicare)

Como el Cliente/Representante que firma al pie, certifico que la información que brindé al presentar una solicitud de pago conforme al Título XVIII de la Ley del Seguro Social es correcta. Autorizo a la agencia arriba mencionada a divulgar mi información médica a la Administración del Seguro Social o a sus intermediarios/aseguradoras para este reclamo o un reclamo relacionado bajo Medicare. Solicito que el pago de los beneficios autorizados se realice a mi nombre. Cedo los beneficios pagaderos por servicios médicos a la agencia arriba mencionada y la autorizo a presentar un reclamo a Medicare para recibir su pago.

PARTE V. **CESIÓN DE BENEFICIOS** (Solamente aplica a Terceros Pagadores)

Como el Cliente/Representante que firma al pie, cedo a la agencia arriba nombrada todos los beneficios brindados conforme a cualquier plan de atención de la salud o póliza de gastos médicos. La suma de dichos beneficios no superará los cargos médicos establecidos por el cronograma de gastos aprobados. Todos los pagos en virtud de este párrafo deben realizarse a la agencia anterior. Soy personalmente responsable de cubrir los gastos que no cubra esta cesión.

PARTE VI. **RECOPILACIÓN, USO O EXONERACIÓN RESPECTO DEL NÚMERO DEL SEGURO SOCIAL** (Esta notificación se proporciona de conformidad con el Artículo 119.071(5)(a), Estatutos de la Florida).

Para los programas de atención médica, el Departamento de Salud de Florida puede recopilar su número del seguro social a los fines de la identificación y la facturación, según lo autorizado por los artículos 119.071(5)(a) 2.a. y 119.071(5)(a)6., Estatutos de la Florida. Al firmar a continuación, presto mi consentimiento para la recopilación, el uso o la divulgación de mi número del seguro social solo a los fines de la identificación y la facturación. No se utilizará para ningún otro propósito. Entiendo que la recopilación de números del seguro social por parte del Departamento de Salud de Florida es imprescindible para el desempeño de los deberes y las responsabilidades, según lo exigido por la ley.

PARTE VII **MI FIRMA A CONTINUACIÓN VERIFICA EL INFORME ANTERIOR Y EL RECIBO DE LA NOTIFICACIÓN DE LOS DERECHOS DE PRIVACIDAD**

_____

Firma del Cliente/Representante del Cliente | Relación propia o del representante con el cliente | Fecha

_____

Testigo (opcional) | Fecha

PARTE VIII. **RETIRO DEL CONSENTIMIENTO**

Yo,_____RETIRO ESTE CONSENTIMIENTO, a partir del_____

Firma del Cliente/Representante del Cliente | Fecha

_____ _____

Testigo (opcional) | Fecha

Nombre del cliente: _____
No. de ID:_____
Fecha de nacimiento: _____

Original al archivo; copia al cliente.

Firma del Cliente/Representante del Cliente

INTERAGENCY CONSENT
FOR SERVICES AND RELEASE OF INFORMATION

Student Name: _____ Date of Birth: _____

Address: _____ Apartment/Unit/Lot: _____

City: _____ Zip Code: _____ Telephone Number: _____

School: ☐ Boca Ciega, Northeast, Gibbs, Pinellas Park, Largo HS ☐ Other School: _____

Check the appropriate box then read and sign the Consent Section:

☐ As the parent/legal guardian of the above-named student, I, _____, consent to the student receiving services from the *Department of Health in Pinellas County* and *Suncoast Center, Inc.*

☐ I, the above-named student, consent and agree to receive services from the *Florida Department of Health* and *Suncoast Center, Inc.*

The expanded services at the school are funded by the Juvenile Welfare Board (JWB) through local taxes. As part of the funding, the *Department of Health in Pinellas* and *Suncoast Center, Inc.* are required to collect additional personally identifiable information on the student for program accountability and quality improvement activities. However, the student will not be denied the basic school health services if you choose not to sign the form. Once the information is received by JWB it is encrypted and de-identified to protect parental and student privacy rights (See JWB Written Statement of Purpose(s) for Collection of Confidential Information form).

Consent Section

I consent to my minor participating in online or paper surveys that will be used for program improvements and enhancements.

I authorize the *Florida Department of Health in Pinellas County and Suncoast Center, Inc.* to release to and receive from the *School Board of Pinellas County* medical/education records (the "Records"). I understand that such Records may contain health information pertaining to psychiatric, drug and/or alcohol diagnosis and treatment, HIV/AIDS as well as educational records, immunization records, suspensions/office referral data, attendance data, referrals to student service teams, and written and verbal communication with school staff related to mental health intervention.

I authorize the *Florida Department of Health in Pinellas County, Suncoast Center, Inc.*, and *School Board of Pinellas County* to release personally identifiable student information, such as student social security number, name, address, date of birth, household number, household living arrangement (parents, single parent, grandparent etc.), and free and reduced lunch information to JWB.

I also authorize the *Florida Department of Health in Pinellas County, Suncoast Center, Inc.,* and *School Board of Pinellas County* to release protected health information and all information pertaining to treatment received at the school clinic, home or anywhere else where I am receiving treatment from these providers and any and all other medical information in their control to JWB. I further authorize the *Florida Department of Health in Pinellas County*, *Suncoast Center, Inc.,* and *School Board of Pinellas County* to release records may which may contain health information pertaining to psychiatric, drug and/or alcohol diagnosis and treatment, HIV/AIDS as well as educational records, immunization records, suspensions/office referral data, attendance data, referrals to student service teams, and written and verbal communication with school staff related to mental health intervention to JWB.

I understand that the Records will be released and received for the purpose of treatment, payment/reimbursement, quality improvement and research activities.

I understand this consent is in place while the above named student is enrolled in one of the above named Pinellas County Schools. This consent will terminate when the above named student is no longer enrolled in or graduates from one of the above named Pinellas County Schools, except for the purpose of research and compliance reviews. I understand I have the right to revoke this consent at any time. If I revoke this consent, it must be in writing and be presented to the health clinic at the above named school. I understand that if I revoke my consent that it will not apply to any information already released and/or used as a result of my prior consent.

I release the School Board of Pinellas County, Florida Department of Health in Pinellas County, Suncoast Center, Inc., and the Juvenile Welfare Board of Pinellas County, their officers, agents, and employees, from liability for the release of information in accordance with this consent.

_____ _____ _____

Signature of parent/guardian or adult student (over 18 years old) Date Relationship to Student

_____ _____

Signature of Witness Date

NOTICE OF PRIVACY PRACTICES

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.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Protected health information includes demographic and medical information that concerns the past, present, or future physical or mental health of an individual. Demographic information could include your name, address, telephone number, social security number and any other means of identifying you as a specific person. Protected health information contains specific information that identifies a person or can be used to identify a person.

Protected health information is health information created or received by a health care provider, health plan, employer, or health care clearinghouse. The Department of Health can act as each of the above business types. This medical information is used by the Department of Health in many ways while performing normal business activities.

Your protected health information may be used or disclosed by the Department of Health for purposes of treatment, payment, and health care operations. *Health care professionals use medical information in the clinics or hospital to take care of you. Your protected health information may be shared, with or without your consent, with another health care provider for purposes of your treatment. The Department of Health may use or disclose your health information for case management and services. The Department of Health clinic or hospital may send the medical information to insurance companies, Medicaid, or community agencies to pay for the services provided you.*

Your information may be used by certain department personnel to improve the department's health care operations. The department also may send you appointment reminders, information about treatment options or other health-related benefits and services.

Some protected health information can be disclosed without your written authorization as allowed by law. Those circumstances include:

- Reporting abuse of children, adults, or disabled persons.
- Investigations related to a missing child.
- Internal investigations and audits by the department's divisions, bureaus, and offices.
- Investigations and audits by the state's Inspector General and Auditor General, and the legislature's Office of Program Policy Analysis and Government Accountability.
- Public health purposes, including vital statistics, disease reporting, public health surveillance, investigations, interventions, and regulation of health professionals.
- District medical examiner investigations;

- Research approved by the department.
- Court orders, warrants, or subpoenas;
- Law enforcement purposes, administrative investigations, and judicial and administrative proceedings.

Other uses and disclosures of your protected health information by the department will require your written authorization. These uses and disclosures may be for marketing and for research purposes, certain uses and disclosure of psychotherapist notes, and the sale of protected health information resulting in remuneration to the Department of Health.

This authorization will have an expiration date that can be revoked by you in writing.

INDIVIDUAL RIGHTS

You have the right to request the Department of Health to restrict the use and disclosure of your protected health information to carry out treatment, payment, or health care operations. You may also limit disclosures to individuals involved with your care. The department is not required to agree to any restriction.

You have the right to be assured that your information will be kept confidential. The Department of Health will make contact with you in the manner and at the address or phone number you select. You may be asked to put your request in writing. If you are responsible to pay for services, you may provide an address other than your residence where you can receive mail and where we may contact you.

You have the right to inspect and receive a copy of your protected health information that is maintained by the Department of Health within 30 days of the Department's receipt of your request.to obtain a copy of your protected health information. You must complete the Department's Authorization to Disclosure Confidential Information form and submit the request to the county health department or Children's Medical Services office. If there are delays in getting you the information, you will be told the reason for the delay and the anticipated date when you will receive your information.

Your inspection of information will be supervised at an appointed time and place. You may be denied access as specified by law.

If you choose to receive a copy of your protected health information, you have the right to receive the information in the form or format you request. If the Department cannot produce it in that form or format, it will give you the information in a readable hard copy form or another form or format that you and the Department agree to.

The Department cannot give you access to psychotherapy notes or certain information being used in a legal proceeding. Records are maintained for specified periods of time in accordance with the law. If your request covers information beyond that time the Department is required to keep the record, the information may no longer be available.

If access is denied, you have the right to request a review by a licensed health care professional who was not involved in the decision to deny access. This licensed health care professional will be designated by the department.

You have the right to correct your protected health information. Your request to correct your protected health information must be in writing and provide a reason to support your requested correction. The Department of Health may deny your request, in whole or part, if it finds the protected health information:

- Was not created by the department.
- Is not protected health information.
- Is by law not available for your inspection.
- Is accurate and complete.

If your correction is accepted, the department will make the correction and tell you and others who need to know about the correction. If your request is denied, you may send a letter detailing the reason you disagree with the decision. The department may respond to your letter in writing. You also may file a complaint, as described below in the section titled Complaints.

You have the right to receive a summary of certain disclosures the Department of Health may have made of your protected health information. This summary does not include:

- Disclosures made to you.
- Disclosures to individuals involved with your care.
- Disclosures authorized by you.
- Disclosures made to carry out treatment, payment, and health care operations.
- Disclosures for public health.
- Disclosures to health professional regulatory purposes.
- Disclosures to report abuse of children, adults, or disabled.
- Disclosures prior to April 14, 2003.

This summary does include disclosures made for:

- Purposes of research, other than those you authorized in writing.
- Responses to court orders, subpoenas, or warrants.

You may request a summary for not more than a 6 year period from the date of your request.

If you received this Notice of Privacy Practices electronically, you have the right to a paper copy upon request.

The Department of Health may mail or call you with health care appointment reminders.

DEPARTMENT OF HEALTH DUTIES

The Department of Health is required by law to maintain the privacy of your protected health information. This Notice of Privacy Practices tells you how your protected health information may be used and how the department keeps your information private and confidential. This notice explains the legal duties and practices relating to your protected health information. The department has the responsibility to notify you following a breach of your unsecured protected health information.

As part of the department's legal duties this Notice of Privacy Practices must be given to you. The department is required to follow the terms of the Notice of Privacy Practices currently in effect.

The Department of Health may change the terms of its notice. The change, if made, will be effective for all protected health information that it maintains. New or revised notices of privacy practices will be posted on the Department of Health website at http://www.floridahealth.gov/about-the-department-of-health/about-us/patient-rights-and-safety/hipaa/index.html and will be available by email and at all Department of Health buildings. Also available are additional documents that further explain your rights to inspect and copy and amend your protected health information.

COMPLAINTS

If you believe your privacy health rights have been violated, you may file a complaint with the: Department of Health's Inspector General at 4052 Bald Cypress Way, BIN A03/ Tallahassee, FL 32399-1704/ telephone 850-245-4141 and with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W./ Washington, D.C. 20201/ telephone 202-619-0257 or toll free 877-696-6775.

The complaint must be in writing, describe the acts or omissions that you believe violate your privacy rights, and be filed within 180 days of when you knew or should have known that the act or omission occurred. The Department of Health will not retaliate against you for filing a complaint.

FOR FURTHER INFORMATION

Requests for further information about the matters covered by this notice may be directed to the person who gave you the notice, to the director or administrator of the Department of Health facility where you received the notice, or to the Department of Health's Inspector General at 4052 Bald Cypress Way, BIN A03/ Tallahassee, FL 32399-1704/ telephone 850-245-4141.

EFFECTIVE DATE

This Notice of Privacy Practices is effective beginning July 1, 2013, and shall be in effect until a new Notice of Privacy Practices is approved and posted.

REFERENCES

"Standards for the Privacy of Individually Identifiable Health Information; Final Rule." 45 CFR Parts 160 through 164. *Federal Register* 65, no. 250 (December 28, 2000).
"Standards for the Privacy of Individually Identifiable Health Information; Final Rule" 45 CFR Part 160 through 164. *Federal Register*, Volume 67 (August 14, 2002).

HHS, Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules under the Health Information Technology for Economic and Clinical Health Act and the Genetic Information and Nondiscrimination Act; Other Modifications to the HIPAA Rules, 78 Fed. Reg. 5566 (Jan. 25, 2013).