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.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires the Georgia Department of Public Health and the County Board of Health (CBOH) to maintain the privacy of your health information, inform you of its legal duties and privacy practices with respect to your health information through this Notice of Privacy Practices, notify you if there is a breach involving your protected health information, agree to restrict disclosure of your health information to your health plan if you pay out-of-pocket in full for health care services and abide by the terms of this Notice currently in effect. We reserve the right to change the terms of this Notice at any time. The Notice will be posted on the website at **www.southwestgeorgiapublichealth.org**. Copies of the Notice are available upon request.

The Department of Public Health and the County Boards of Health will follow this Notice.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

Treatment: We may use or disclose your health information to provide you with treatment or services. County Boards of Health may disclose your health information to doctors, nurses or other healthcare personnel involved in your care. For example, County Boards of Health may share your information with programs involved in your follow-up care, such as the Babies Can't Wait program. Also, the DPH Public Health Laboratory will return lab test results to the person who ordered the tests, and those results may be used for your treatment or follow-up care.

Payment: We may use or disclose your health information to bill and collect payment for the services that you receive. For example, your health insurance company may need to provide your health plan with information about the treatment you received so that it can make payment or reimbursement for services provided to you.

Health Care Operations: We may use and disclose information about you for health care operations. For example, we may review treatment and services to evaluate the performance of our staff in caring for you, and to determine what additional services should be provided.

Appointment Reminders, Follow-Up calls: We may use or disclose medical information about you to remind you of an upcoming appointment or to check on you after you have received treatment.

Individuals Involved in Your Care: Unless you tell us otherwise, we may disclose your health information to a family member, relative, or close friend who is involved in your care or assists in taking care of you. We may also disclose information to someone who helps pay for your care. We may disclose your health information to an organization assisting with disaster relief to help notify your family member, relative, or close friend of your condition, status and location.

Business Associates: We may disclose your information to contractors (business associates) who provide certain services to us. We will require these business associates to appropriately safeguard your information.

Public Health Activities: We may disclose your health information for public health activities which include: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting reactions to medications or problems with products or notifying a person of product recalls.

Victims of Abuse, Neglect or Domestic Violence: We may disclose your medical information to notify the appropriate government authority if we believe you have been the victim of abuse, neglect or domestic violence. We will only disclose this if you agree, or when required or authorized by law or regulation.

Health Oversight Activities: We may disclose your health information to a health oversight agency that is authorized to conduct audits, investigations, inspections, licensure and other activities necessary to monitor the health care system, government programs and compliance with civil rights laws.

Judicial and Administrative Proceedings: We may disclose your health information if ordered to do so by a court or administrative tribunal that is handling a lawsuit or other dispute. We may also disclose your health information in response to a subpoena, discovery request, or other lawful process, but only if reasonable efforts have been made to notify you of the request or to protect the health information requested.

Law Enforcement: We may release health information to law enforcement to comply with a court order, warrant, subpoena or similar process to identify or locate a suspect, fugitive, material witness or missing person about the victim of a crime in certain circumstances if we believe a death resulted from criminal conduct to report a crime occurring on our premises in emergencies, to report a crime, the location or victims of the crime, or the identity, description and location of the person committing the crime.

Research: Under certain circumstances we may use or disclose your health information for research. In most cases, we will ask for your written authorization before doing so. Sometimes, we may use or disclose your health information for research without your written authorization. In those cases, the use or disclose of your health information without your consent will be approved by an Institutional Review Board or Privacy Board.

Coroners, Medical Examiner and Funeral Directors: We may disclose health information to a coroner or medical examiner. This may be necessary, for example, to determine the cause of death. We may also disclose medical information to funeral directors as necessary to carry out their duties.

To Avert a Serious Threat to Health or Safety: We may use or disclose your health information if necessary to prevent or lessen a serious and imminent threat to your safety, another person, or the general public. We will only disclose your information to a person who can prevent or lessen that threat.

National Security and Intelligence Activities and Protective Services for the President: We may disclose your health information to authorized federal officials conducting intelligence and other national security activities. We may also disclose your health information to authorized federal officials for the provisions of protective services to the President, other authorized persons, foreign heads of state or to conduct special investigations.

Military and Veterans: We may disclose the health information of Armed Forces personnel to appropriate military command authorities for the execution of their military mission. We may also disclose health information about foreign military personnel to foreign military authorities.

Inmates: If you are an inmate, we may disclose your health information to the law enforcement official or correctional institution having custody to provide you with health care, and to protect your health or safety or that of other inmates or persons involved in supervising or transporting inmates.

Workers' Compensation: We may release your health information for workers' compensation or similar programs that provide benefits for work-related injuries.

As Required by Law: We will disclose your health information when required to do so by law.

Except in limited circumstances, we must obtain your authorization for 1) any use or disclosure of psychotherapy notes 2) any use or disclosure of your health information for marketing, and 3) the sale of your health information. If your health information has information relating to mental health, substance abuse treatment, or HIV/ AIDS, we are required by law to obtain your written consent before disclosing such information. Any other use or disclosure not mentioned in this Notice will be made only with your written authorization, and you can revoke that authorization at any time. The revocation must be in writing, but will not apply to disclosures made in reliance on your prior authorization.

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

Right to Inspect and Copy: You have the right to inspect and copy your records. You must submit your request in writing to the HIPAA Privacy Officer, PO Box 148, Thomasville, GA 31799, and include your name, date of birth, social security number, and the location where services were received if you received services at a local county health department. We may deny your request and in some circumstances, you may request a review of the denial.

Right to Request an Amendment of PHI: You may request that we amend information that we have about you, for as long as we keep that information. You must submit your request in writing to the HIPAA Privacy Officer, PO Box 148, Thomasville, GA 31799, and include your name, date of birth, social security number, a reason that supports your request, and the location where services were received if you received services at a local county health department. Your request may be denied if 1) the information was not created by us unless the creator of the information is not available to make the requested amendment, 2) the information is not kept by us 3) the information is not available for your inspection, or 4) the information is accurate and complete.

Right to an Accounting of Disclosures: You have the right to receive an accounting of disclosures of your health information made by us in the six years prior to the date on which the accounting is requested. The accounting will not include any disclosures 1) to you or your personal representative 2) made pursuant to your written authorization 3) made for treatment, payment or business operations 4) made to your friends and family involved in your care or payment for your care 5) that were incidental to permissible uses or disclosures of your health information 6) of limited portions of your health information that excludes identifiers 7) made to federal officials for national security and intelligence activities, and 8) to correctional institutions or law enforcement officers about inmates. To request an accounting of disclosures, submit your request in writing to the HIPAA Privacy Officer, PO Box 148, Thomasville, GA 31799. Please include your name, date of birth, social security number, the period for which the accounting is being requested, and the location where services were received if you received services at a local county health department.

Right to Request Restrictions: You may request that we restrict the way we use and disclose your health information for treatment, payment or health care operations. You may also request that we limit how we disclose your health information to a family member, relative or close friend involved in your care or payment for your care. We are not required to agree to your request, but if we do, we will comply with your request unless you need emergency treatment and the information is needed to provide the emergency treatment. We may terminate our agreement to a restriction once we notify you of the termination. To request a restriction on the use or disclosure of your health information, please send your request in writing to the HIPAA Privacy Officer, PO Box 148, Thomasville, GA 31799. Please include your name, social security number, and date of birth, what information you want to limit, to whom you want the limitation to apply, and the location where services were received if you received services at a local county health department.

Right to Request Confidential Communications: You may make reasonable requests to receive communications of your health information by alternate means or at alternate locations. For example, you may ask to be contacted only by mail, and not by phone. To request confidential communications, please send your request in writing to the HIPAA Privacy Officer, PO Box 148, Thomasville, GA 31799. Please include your name, social security number, date of birth, how you would like to be contacted, and the local county health department where you received services.

Right to Receive a Paper Copy of this Notice: You have a right to receive a paper copy of this Notice, which you may request at any time. You may obtain a paper copy by writing to the HIPAA Privacy Officer, PO Box 148, Thomasville, GA 31799.

COMPLAINTS

If you believe that your privacy rights have been violated, you may send a written complaint to the HIPAA Privacy Officer, PO Box 148, Thomasville, GA, 31799. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint.

FOR FURTHER INFORMATION

For further information you may contact the HIPAA Privacy Officer at 229-226-4241.

THIS NOTICE IS EFFECTIVE February 3, 2014.

HIPAA SECURITY OFFICER

The HIPAA Security Officer may also be reached at 229-226-4241 or by writing to:

HIPAA Security Officer
PO Box 148
Thomasville, GA 31799

Southwest Health District
2014-2015 Influenza Vaccine Consent Form/School-Based Flu Clinics

STUDENT'S NAME (Last)	(First)	(M.I.)	SCHOOL NAME:	
STUDENT'S DATE OF BIRTH (mm/dd/yyyy)	STUDENT'S AGE	GENDER: M / F	TEACHER	GRADE
ETHNICITY *(Please Circle)* Not Hispanic/Latino Hispanic/Latino	RACE *(Please Circle)* African American, White, American Indian, Asian, Alaska Native, Native Hawaiian, Other Pacific Islander, Other		PARENT/ LEGAL GUARDIAN'S NAME	
HOME ADDRESS			PARENTAL/ GUARDIAN PHONE NUMBER(S)	
CITY STATE		ZIP CODE		

INSURANCE INFORMATION: Do you have Insurance that covers vaccines? Yes / No Check health insurance provider below. (You will not be charged for this vaccine.) ☐ BCBS Policy/Group # _____/_____ ☐ AETNA Policy/Group # _____/_____
☐ Medicaid/Wellcare/Peachstate/Amerigroup/Peachcare # _____ ☐No Insurance ☐Other: _____

Section 2: Medical Information. The following questions will help us to know if this student can receive the 2014-2015 Influenza Vaccine. **Please circle Yes or No for each question.*

13. Has the student ever had a serious reaction to any influenza vaccine?	Yes	No
2. Has the student child ever had a serious reaction to eggs?	Yes	No
3. Has the student ever had Guillain-Barre Syndrome (GBS)?	Yes	No
4. a.) Does the student have asthma or a wheezing condition? b.) If YES, does your child use inhalers and/ or breathing treatments?	a. Yes b. Yes	a. No b. No
5. Is the student on long-term aspirin or aspirin-containing therapy (For example: does your child take aspirin everyday)	Yes	No
6. Does the student have any significant or chronic (long term) health conditions? (For example: diabetes, sickle cell disease, heart conditions, lung conditions, seizure disorders, cerebral palsy, muscle or nerve disorders, etc.)	Yes	No
7. Does the student have a weak immune system (for example, from HIV, cancer, or medications such as steroids or those used to treat cancer?)	Yes	No
8. Is the student or could the student be pregnant?	Yes	No
9. Does the student live with or expect to have close contact with a person whose immune system is severely compromised and who must be in protective isolation (e.g., an isolation room of a bone marrow transplant unit)?	Yes	No
10. Has the student received any vaccines in the last four weeks? If yes, please list: _____	Yes	No
11. Is the student allergic to latex?	Yes	No

Section 3: Consent:

***If you selected YES TO QUESTION 1 - 3 in section 2 your child WILL NOT be able to receive INJECTABLE OR INTRANASAL flu vaccine at school.* Contact your healthcare provider regarding flu vaccine for your child. *If you selected YES to any of QUESTIONS 4-9 in section 2, your child WILL NOT be able to receive the INTRANASAL vaccine and CAN ONLY RECEIVE the INJECTABLE vaccine.**

CONSENT FOR STUDENT TO RECEIVE INFLUENZA VACCINE: ***By signing below, I give permission for the student named above to receive the 2014-2015 Influenza vaccine.*** I acknowledge that the student and medical information provided above is correct. I have been given a copy of the Vaccine Information Statements (VIS) dated 08/19/2014 for the influenza vaccines and a copy of the NOTICE of PRIVACY PRACTICES. I have had a chance to ask questions which were answered to my satisfaction.I understand the benefits and risks of the influenza vaccine that will be given to the student that I am authorized to represent. I understand that participation and receipt of the influenza vaccine through this program is completely voluntary. By signing below, I give permission for the student listed above to receive the IntraNASAL or Injectable Influenza Vaccine. **The consent form will provide permission to vaccinate for both doses, if needed. (See VIS) If this consent form is not filled in completely, signed, dated, and returned, the student will not be vaccinated at school.**

Signature of Parent/ Legal Guardian: _____ **Date:** _____

Health Department Staff Use Only

Type Vaccine	Date Administered	Mfg. /Lot#/Exp. Date	Administration Route	Nurse Signature	Clerk initial/date entered in VHN
1st Intranasal: VFC /CP 2nd Intranasal: VFC/CP	1st _____ 2nd _____	1st _____ 2nd _____	Intranasal Intranasal	1st _____ 2nd _____	
1st Inactivated: VFC /CP 2nd Inactivated: VFC/CP	1st _____ 2nd _____	1st _____ 2nd _____	IM / LD/LM RD/RM IM / LD/LM RD/RM	1st _____ 2nd _____	
Allergy Status Verified	**Right Vaccine/No contraindications**	**Right Formulation for Patient's Age**	**Right Patient/Verify @ Minimum Name and DOB**	**Expiration Date Valid**	**Right Dose/Route**

Revised 08/27/2014