

MRN:
Patient Name:
(Patient Label)

NOTICE O: PRIVACY PRACTICE

Effective Date: March 1, 2013

UNIVERSITY OF CALIFORNIA LOS ANGELES - UCLA HEALTH

THIS NOTICE DESCRIBES HOW PHYSICAL AND MENTAL HEALTH INFORMATION (“health information”) ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

UCLA HEALTH

UCLA Health is one of the health care components of the University of California. The University of California health care components consist of the UC medical centers, the UC medical groups, clinics and physician offices, the UC schools of medicine and other UC health professions schools, the student health service areas, employee health units, and the administrative and operational units that are part of the health care components of the University of California.

The University of California, including UCLA Health, is a teaching and research institution. All patient care is overseen and supervised by an attending physician and provided by a team of health care professionals. Residents, fellows, students and graduate students of health care professions schools may participate in examinations or procedures and in the care of patients as a part of the health care education programs of the institution.

This Notice applies to information and records regarding your health care maintained at UCLA Health.

OUR PLEDGE REGARDING YOUR HEALTH INFORMATION

UCLA Health is committed to protecting information regarding your health treatment and related health care services about you. We create a record of the care and services you receive at UCLA Health for use in your care and treatment.

This Notice tells you about the ways in which we may use and disclose your health information. It also describes your rights and certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- make sure that your health information is protected;
- give you this Notice describing our legal duties and privacy practices with respect to health information about you; and
- follow the terms of the Notice that is currently in effect.

MRN:
Patient Name:
(Patient Label)

NOTICE O: PRIVACY PRACTICE

Effective Date: March 1, 2013

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following sections describe different ways that we may use and disclose your health information. For each category of uses or disclosures we will describe them and give some examples. Some information such as certain drug and alcohol information and HIV information is entitled to special restrictions related to its use and disclosure. UCLA Health abides by all applicable state and federal laws related to the protection of this information. Not every use or disclosure will be listed. All of the ways we are permitted to use and disclose information, however, will fall within one of the following categories.

****Please note that the sections marked with ** apply only to inpatient mental health information**

For Treatment. We may use health information about you to provide you with medical or psychological treatment or services. We may disclose health information about you to doctors, nurses, technicians, students, or other health system personnel who are involved in taking care of you in the health system. For example, a doctor treating you for a condition may need to know what medications you are currently taking, because the medications may affect what other medications may be prescribed for you. In addition, the doctor may need to tell the hospital's food service if you are taking certain medications so that we can arrange for appropriate meals that will not interfere or improperly interact with your medication. We may also share health information about you with other UCLA Health personnel or non-UCLA Health providers, agencies or facilities who are treating you for a medical or psychological condition, in order to provide or coordinate the different things you need, such as prescriptions or types of therapy. We also may disclose health information about you to people outside UCLA Health who may be involved in your continuing health or medical care after you leave UCLA Health such as other health care providers, transport companies, community agencies and family members.

For Payment. We may use and disclose health information about you so that the treatment and services you receive at UCLA Health or from other entities, such as an ambulance company, may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give information to your health plan about therapy you received at UCLA Health so your health plan will pay us or reimburse you for the therapy. We may also tell your health plan about a proposed treatment to determine whether your plan will cover the treatment.

For Health Care Operations. We may use and disclose health information about you for UCLA Health operations. These uses and disclosures are made for quality of care and medical staff activities, UCLA Health health sciences education, and other teaching programs. Your health information may also be used or disclosed to comply with law and regulation, for contractual obligations, patients' claims, grievances or lawsuits, health care contracting, legal services, business planning and development, business management and administration, the sale of all or part of UCLA Health to another entity, underwriting and other insurance

MRN:
Patient Name:

(Patient Label)

NOTICE O: PRIVACY PRACTICE

Effective Date: March 1, 2013

activities and to operate the health system. For example, we may review health information to find ways to improve treatment and services to our patients. We may also disclose information to doctors, nurses, technicians, medical and other students, and other health system personnel for performance improvement and educational purposes.

Appointment Reminders. We may contact you to remind you that you have an appointment at UCLA Health.

Treatment Alternatives. We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services. We may contact you about benefits or services that we provide.

Fundraising Activities. We may contact you to provide information about UCLA Health sponsored activities, including fundraising programs and events. We would only use contact information, such as your name, address and phone number and the dates you received treatment or services at UCLA Health.

Hospital Directory (does not apply to patients admitted to the Resnick Neuropsychiatric Hospital at UCLA). If you are hospitalized, we may include certain limited information about you in the hospital directory. This is so your family, friends, and clergy can visit you in the hospital and generally know how you are doing. This information may include your name, location in the hospital, your general condition (e.g. fair, stable, etc.) and your religious affiliation. The directory information, except for your religious affiliation, may also be released to people who ask for you by name. Your religious affiliation may be given to members of the clergy, such as ministers or rabbis, even if they don't ask for you by name. You may restrict or prohibit the use or disclosure of this information by notifying the Director of Patient Access Services.

****Individuals Involved In Your Care:** We may tell your family about your general condition and that you are in the hospital unless you request we do not provide this information. Upon request of a family member, and with your consent, we may give the family member notification of your diagnosis, prognosis, prescribed medications, their side effects, and your progress. If your spouse, parent, child, or sibling makes a request for information, and you are unable to authorize the release of such information, we are required to give notification of your presence in the hospital, except to the extent prohibited by federal law. Upon your admission, we are required to make reasonable attempts to notify your next of kin or any other person designated by you, of your admission. Upon request of a family member, we are required to provide information regarding your release, transfer, serious illness, injury, or death, unless you request that this information not be provided.

Research. The University of California is a research institution. All research projects conducted by the University of California must be approved through a special review process

MRN:
Patient Name:
(Patient Label)

NOTICE O: PRIVACY PRACTICE

Effective Date: March 1, 2013

to protect patient safety, welfare and confidentiality. Your health information may be important to further research efforts and the development of new knowledge. We may use and disclose health information about our patients for research purposes, subject to the confidentiality provisions of state and federal law.

On occasion, researchers contact patients regarding their interest in participating in certain research studies. Enrollment in those studies can only occur after you have been informed about the study, had an opportunity to ask questions, and indicated your willingness to participate by signing a consent form. When approved through a special review process, other studies may be performed using your health information without requiring your informed consent. For example, a research study may involve a chart review to compare the outcomes of patients who received one medication to those who received another for the same condition.

As Required By Law. We will disclose health information about you when required to do so by federal or state law.

To Avert a Serious Threat to Health or Safety. We may use and disclose health information about you when necessary to prevent or lessen a serious and imminent threat to your health and safety or the health and safety of the public or another person. Any disclosure would be to someone able to help stop or reduce the threat.

Organ and Tissue Donation. 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 or tissue donation and transplantation.

Public Health Disclosures. We may disclose health information about you for public health purposes. These purposes generally include the following:

- preventing or controlling disease (such as cancer and tuberculosis), injury or disability;
- reporting vital events such as births and deaths;
- reporting child abuse or neglect;
- reporting adverse events or surveillance related to food, medications or defects or problems with products;
- notifying persons of recalls, repairs or replacements of products they may be using;
- notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- notifying the appropriate government authority if we believe a patient has been the victim of abuse or neglect and make this disclosure as authorized or required by law;
- notifying the coroner of a patient's death;
- notifying emergency response employees regarding possible exposure to HIV/AIDS, to the extent necessary to comply with state and federal law;
- notifying multidisciplinary personnel teams relevant to the prevention, identification, management, or treatment of an abused child and the child's parents or an abused elder or dependent adult.

MRN:
Patient Name:

(Patient Label)

NOTICE O: PRIVACY PRACTICE

Effective Date: March 1, 2013

Health Oversight Activities. We may disclose health information to governmental, licensing, auditing, and accrediting agencies as authorized or required by law.

Lawsuits and Other Legal Actions. In connection with lawsuits or other legal proceedings, we may disclose health information about you in response to a court or administrative order, or in response to a subpoena, warrant, summons or other lawful process.

****We may disclose mental health information to courts, attorneys and court employees in the course of conservatorship, writ and certain other judicial or administrative proceedings.**

Law Enforcement. We may release health information to law enforcement officials as follows:

- as needed for the protection of certain elected officials, others and their families, as required by law;
- for the protection of persons when necessary to protect them from a serious danger of violence [information may also be released to others who may be able to help stop or reduce the danger]
- ****when requested at the time of a patient’s involuntary hospitalization [information may also be released to the county mental health director/designee];**
- ****when reporting that a patient, while hospitalized, has been a victim or perpetrator of certain specified crimes;**
- ****when requested by an officer who lodges a warrant with the facility**
- ****to identify or locate a suspect, fugitive, material witness, certain escapees and certain missing persons;**
- in response to a court order, subpoena, warrant, summons or similar process;

Advocacy Groups. We may release health information to Protection and Advocacy, Inc. with a patient or patient representative’s authorization or for the purposes of certain investigations. We may release health information to the County Patients’ Rights Office with a patient or patient representative’s authorization, or for investigations resulting from reports required by law to be submitted to the Director of Mental Health.

Protection of Elective Constitutional Officers. We may disclose health information about you to government law enforcement agencies as needed for the protection of federal and state elective constitutional officers and their families.

****Department of Justice:** We may disclose limited information to the California Department of Justice for movement and identification purposes about certain criminal patients, or regarding persons who may not purchase, possess or control a firearm or deadly weapon.

Senate and Assembly Rules Committees. We may disclose your health information to the Senate or Assembly Rules Committee for the purpose of legislative investigation, as required by law.

MRN:
Patient Name:

(Patient Label)

NOTICE O: PRIVACY PRACTICE

Effective Date: March 1, 2013

****Inmates.** If you are an inmate of a correctional institution or under the custody of law enforcement officials, we may release mental health information about you to the correctional institution as authorized or required by law.

PSYCHOTHERAPY NOTES: *Psychotherapy notes* means notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual’s medical record. *Psychotherapy notes* excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

Psychotherapy notes may not be disclosed without your authorization except in certain limited circumstances:

- Use or disclosure in supervised mental health training programs for students, trainees, or practitioners;
- Use or disclosure by the covered entity to defend a legal action or other proceeding brought by the individual;
- A use or disclosure that is required by law
- A use or disclosure that is permitted:
 - for legal and clinical oversight of the psychotherapist who made the notes,
 - to prevent or lessen a serious and imminent threat to the health or safety of the public

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

Your health information is the property of UCLA Health. You have the following rights, however, regarding health information we maintain about you:

Right to Inspect and Copy. With certain exceptions, you have the right to inspect and/or receive a copy of your health information.

To inspect and/or to receive a copy of your health information, you must submit your request in writing to:

For mental health information:
UCLA Neuropsychiatric Hospital
Medical Records Department
300 UCLA Medical Plaza, Suite 1100
Los Angeles, CA 90095

MRN:
Patient Name:
(Patient Label)

NOTICE O: PRIVACY PRACTICE

Effective Date: March 1, 2013

For physical health information:

Health Information Management Services Department – Release of Information
UCLA Health
10833 Le Conte Avenue, Room CHS-BH265
Los Angeles, CA 90095-7305.

If you request a copy of the information, there is a fee for these services.

We may deny your request to inspect and/or to receive a copy in certain limited circumstances. If you are denied access to health information, in most cases, you may have the denial reviewed. Another licensed health care professional chosen by UCLA Health will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Request an Amendment or Addendum. If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information or add an addendum (addition to the record). You have the right to request an amendment or addendum for as long as the information is kept by or for UCLA Health.

Amendment. To request an amendment, your request must be made in writing and submitted to:

Health Information Management Services Department - UCLA Health
10833 Le Conte Avenue, Room CHS BH265
Los Angeles, CA 90095-7305

In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by UCLA Health;
- Is not part of the mental health information kept by or for UCLA Health;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete in the record.

Addendum. To submit an addendum, the addendum must be made in writing and submitted to:

Health Information Management Services Department
UCLA Health, 10833 Le Conte Avenue, Room CHS BH265
Los Angeles, CA 90095-7305.

An addendum must not be longer than 250 words per alleged incomplete or incorrect item in your record.

MRN:
Patient Name:

(Patient Label)

NOTICE O: PRIVACY PRACTICE

Effective Date: March 1, 2013

Right to an Accounting of Disclosures. You have the right to receive a list of certain disclosures we have made of your health information.

To request this accounting of disclosures, you must submit your request in writing to:
Health Information Management Services Department, UCLA Health
10833 Le Conte Avenue, Room CHS BH-265
Los Angeles, CA 90095-7305.

Your request must state a time period that may not be longer than the six previous years and may not include dates before April 14, 2003. You are entitled to one accounting within any 12-month period at no cost. If you request a second accounting within that 12-month period, there will be a charge for the cost of compiling the accounting. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information to a family member about a surgery you had.

To request a restriction, you must make your request in writing to:
Health Information Management Services Department
UCLA Health
10833 Le Conte Avenue, Room CHS BH265
Los Angeles, CA 90095-7305

In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, only to you and your spouse. *We are not required to agree to your request.* If we do agree, our agreement must be in writing, and we will comply with your request unless the information is needed to provide you emergency treatment.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we contact you only at home or only by mail.

To request confidential communications, you must make your request in writing to:

For mental health information:
UCLA Neuropsychiatric Hospital
Medical Records Department
300 UCLA Medical Plaza, Suite 1100
Los Angeles, CA 90095.

MRN:
Patient Name:
(Patient Label)

NOTICE O: PRIVACY PRACTICE

Effective Date: March 1, 2013

For physical health information:

Health Information Management Services Department – Release of Information
UCLA Health, 10833 Le Conte Avenue Room CHS-BH265
Los Angeles, CA 90095-7305

We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

Copies of this Notice are available throughout UCLA Health, or you may obtain a copy at our website, <http://www.uclahealth.org>.

CHANGES TO UCLA HEALTH’S PRIVACY PRACTICES AND THIS NOTICE

We reserve the right to change UCLA Health’s privacy practices and this Notice. We reserve the right to make the revised or changed Notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice throughout UCLA Health. The Notice will contain the effective date on the first page in the top right-hand corner. In addition, at any time you may request a copy of the current Notice in effect.

QUESTIONS OR COMPLAINTS

If you have any questions about this Notice, please contact:
UCLA Health Office of Compliance Services – Privacy
924 Westwood Boulevard, Suite 520
Los Angeles, CA 90024 (310) 794-8638.

If you believe your privacy rights have been violated, you may file a complaint with UCLA Health or with the Secretary of the Department of Health and Human Services. To file a complaint with UCLA Health contact:
UCLA Health Office of Compliance Services – Privacy
924 Westwood Boulevard, Suite 520
Los Angeles, CA 90024 (310) 794-8638.

To file a complaint with the Secretary of the Department of Health and Human Services, contact the: Department of Health and Human Services, Office for Civil Rights.

You will not be penalized for filing a complaint.

MRN:
Patient Name:

(Patient Label)

NOTICE O: PRIVACY PRACTICE

Effective Date: March 1, 2013

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this Notice will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written permission. You understand that we are unable to take back any disclosures we have already made with your permission, and that we will retain our records of the care provided to you as required by law.

MRN:
Patient Name:

(Patient Label)

NOTICE O: PRIVACY PRACTICE

Effective Date: March 1, 2013

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT OF RECEIPT

The UCLA Health Notice of Privacy Practices provides information about how we may use and disclose protected health information about you.

In addition to the copy we are providing you, copies of the current notice are available by accessing our website at www.uclahealth.org and may be obtained throughout UCLA Health.

I acknowledge that I have received the Notice of Privacy Practices.

_____	_____	_____
Signature of Patient or Patient's Representative	Date	Time
_____	_____	_____
Print Name	Relationship to Patient	
_____	_____	_____
Interpreter (if applicable)	Interpreter ID #	

COMPLETE IF WRITTEN ACKNOWLEDGMENT WAS NOT OBTAINED

Please document your efforts to obtain acknowledgment and reason it was not obtained.

1. Notice of Privacy Practices Given – Patient Unable to Sign. _____
2. Notice of Privacy Practices Given – Patient Declined to Sign. _____
3. Notice of Privacy Practices and Acknowledgment Mailed to Patient. _____
4. Other Reason Patient Did Not Sign: _____

_____	_____	_____
Signature of UCLA Health Representative	Date	Time
_____	_____	_____
Print Name	Department	