



Pavillon

Process for Requesting Medical Records

To request a copy of a medical record, please use the following steps:

- 1) Complete and Sign the Medical Records Authorization to Release Information form. Failure to complete the form in its entirety may cause unnecessary delays in obtaining the copy of the record. The completed form must have the signature of the patient to be processed.
- 2) The completed form must be returned via fax, standard mail, or a courier service such as FedEx or UPS. These forms are not acceptable via email.

If sending via standard mail or a courier service, please use the following address:

Pavillon
Medical Records Department
241 Pavillon Place
Mill Spring, NC 28756

If sending by fax, please use the following number:

Medical Records Department Fax Number: 888-480-4691

- 3) There is a minimum fee of \$10.00 to process each request (NC GS 90-411). The cost for processing the request is as follows:
 - 75 cents per page for the first 25 pages;
 - 50 cents per page for pages 26 through 100; and
 - 25 cents per page for pages over 100

If the number of pages is less than 25, the minimum fee will be charged.

- 4) As soon as the cost for processing the request has been determined, the Medical Records Department will contact the requestor with payment options.
- 5) Records will be sent as soon payment is received. Please allow up to 30 days for requests to be processed.



Medical Records Authorization to Release Information (ONE PERSON/ORG Per RELEASE)

I, (Patient Name) _____ (DOB: _____) hereby authorize Pavillon to release information to and/or obtain information from the following individual(s) and/or organizations:

Organization Name (if applicable) _____ Dates of Service: _____

Name: _____ Title/Relationship: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

Email: _____

INFORMATION TO BE RELEASED:

- Status with program (such as date of admission, general progress, date and status of discharge)
- Compliance with program rules/goals (such as attendance, participation, attitude)

Assessments Findings:

- | | |
|--|---|
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Clinical Progress Notes (TPR, Individual, Family, Case Management, General, DAP, Session, Crisis Intervention, Intake, Group, etc) |
| <input type="checkbox"/> Labs (Bloodwork, genetic and drug tests) | <input type="checkbox"/> Master Treatment Plan |
| <input type="checkbox"/> Medication Info/MAR | <input type="checkbox"/> Early Intervention Plan |
| <input type="checkbox"/> Medical & Nursing Notes | <input type="checkbox"/> Continuing Care Plan & CCP Notes |
| <input type="checkbox"/> Initial Counselor Assessment | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Integrated Clinical Summary | <input type="checkbox"/> Four Day Professional Assessment Summary |
| <input type="checkbox"/> Psychological Evaluations and Psychological Notes | <input type="checkbox"/> Four Day Professional Assessment Evaluation |
| <input type="checkbox"/> Psychiatric Evaluations and Psychiatric Notes | |

Other: _____

- Any and all records and other information, whether recorded or not, created by, received or acquired by Pavillon, including, but not limited to, all the specific information listed in this release

INFORMATION IS RELEASED FOR THE FOLLOWING PURPOSE:

- Continuation of Care Legal Reasons Other _____

I voluntarily sign this authorization and I understand that my health care will not be affected if I do not sign this form. This consent shall expire in eighteen (18) months after the date of my signature unless this earlier date/event/condition_____. I agree that this length of time is no longer than reasonably necessary to serve the purpose for which the release is given. I understand that I may revoke this consent (in writing) at any time. If I choose to revoke this consent in the future, I understand that such future revocation cannot apply to information already released and/or obtained under authority of this release prior to the date of such revocation. This consent is subject to revocation at any time except to the extent that Pavillon has already acted in reliance on it. I understand that receiving services will not be made contingent on signing this or any other authorization to release information.

I understand that my drug and alcohol treatment records are protected under the Federal regulations governing confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2 and the Health Insurance Portability and Accountability Act (HIPAA) of 1996, 45 C.F.R. parts 160 & 164 and state laws regarding privilege and cannot be disclosed without my written consent unless otherwise provided for by the regulations or state law. By signing, I am voluntarily providing written consent to release the above described records and waive any state privilege relating to the records.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Administrative Approval: _____

241 Pavillon Place, P.O. Box 189 Mill Spring, NC 28756
Phone: 800-392-4808 Fax: 888-480-4691

Pavillon International

DBA Pavillon

Privacy Policy Statement

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.

Pavillon and all associates at all locations values you as a patient and respects your right to privacy. We pledge our commitment to treating your information responsibly. We restrict access to your health information to those employees who need to know in order to provide appropriate treatment or services to you or to conduct Pavillon business on your behalf.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA), requires all health care records and other individually identifiable health information (protected health information or PHI) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. The federal law gives you, the patient, significant rights to understand and control how health information is used.

OUR LEGAL DUTY

Pavillon and all associates at all locations are required by applicable federal HIPAA law to maintain the privacy of your protected health information, except where federal and state regulations apply regarding ongoing child and/or vulnerable adult abuse, and to notify you following a breach of unsecured protected health information. We are also required to give you this Statement about our privacy policy, our legal duties, and your rights concerning your health information. This statement is effective on 9/23/2013 and complies with the Omnibus HIPAA Final Rule published January 25, 2013. We are required to abide by the terms of the Privacy Policy Statement in effect.

CHANGES TO THIS NOTICE

We reserve the right to change our privacy policy and the terms of this Statement at any time, and we may make the changes effective for health information we have already created or received about you, provided such changes are permitted or required by applicable law. Before we make a significant change in our privacy policy that materially affects the information in this Statement, we will change this Statement and make the new Statement available to you. We will provide you with a revised Statement in printed form.

For more information about our privacy policy, or for additional copies of this Statement, please contact us by using the information listed at the end of this Statement.

USES AND DISCLOSURES OF HEALTH INFORMATION

The following categories describe different ways that we use and disclose protected health information about you **only under a signed release.**

For Treatment. We may use or disclose your protected health information for your treatment, such as to a doctor or other healthcare provider providing treatment to you.

For Payment. We may use and disclose your protected health information to obtain payment for services we provide to you, such as to obtain reimbursement for services we provided.

Your Authorization. You may give us a written authorization or release to use your protected health information for any purpose that you deem necessary. You may revoke an authorization or release at any time; the revocation must be in writing. Your revocation will not affect any use or disclosures permitted by your release while it was in effect.

Individuals Involved in Your Care or Payment for Care. With your signed release, your protected health information may be disclosed to a family member, friend or other person to help with your healthcare.

Marketing. We may not use your protected health related information for marketing purposes. We may not sell your protected health information.

Research. We do not disclose protected health information for research purposes without your written consent. Information without patient identifiable data may be used for generic research.

Workers' Compensation and Disability. With your signed release, protected health information about you may be disclosed for workers' compensation, disability or similar programs.

The following categories describe different ways that we may use and disclose protected health information about you **without a signed release.**

Required by Law. Federal, state or local law may require us to use or disclose your protected health information.

Law Enforcement. We may release protected health information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may disclose protected health information to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law. We may disclose protected health information to funeral directors, consistent with applicable law, as necessary to carry out their duties.

Organ, Eye, Tissue Donation. We may disclose protected health information to organizations that procure, bank or transplant organs or tissues.

Health Oversight Activities. We may disclose protected health information to a health oversight agency for activities authorized by law.

Public Health Activities. We may disclose protected health information about you for public health activities such as to prevent or control disease, injury or disability; to report reactions to medications, food, or problems with products; to authority authorized by law to receive reports of child abuse or neglect.

Health Care Operations. We may use and disclose your protected health information in connection with our health care operations. These uses and disclosures are necessary to run The Pavillon and to make sure all of our patients receive quality care. Health care operations may also include accreditation and licensing. We may use your information to provide information on services that may be of interest to you.

Military and Veterans. If you are a member of the armed forces, we may release protected health information as required by military command authorities. We also may release Protected Health Information to the appropriate foreign military authority if you are a member of a foreign military.

National Security and Intelligence Activities. We may release protected health information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

To Avert a Serious Threat to Health or Safety. We may use and disclose protected health information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Victim of Abuse, Neglect, or Domestic Violence. We may use or disclose your protected health information to an authorized government authority, including a social service or protective services agency if we reasonably believe you to be a victim of abuse, neglect, or domestic violence.

Data Breach Notification Purposes. We may use or disclose your protected health information to provide legally required notices of unauthorized access to or disclosure of your health information.

Judicial and Administrative Proceedings. We may disclose your protected health information in response to a court or administrative tribunal order, a subpoena, a discovery request, or other lawful process but only when we have followed procedures required by law.

Business Associates. We may disclose protected health information to our “business associates” who perform certain functions or activities that involve the use or disclosure of protected health information on behalf of, or provides services to us. All of our business associates are obligated to protect the privacy of protected health information and may use the information only for the purposes for which the business associate was engaged.

Secretary of Health and Human Services. We are required to disclose your information to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Rules.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your protected health information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever practical to do so.

OTHER CATEGORIES. Other uses and disclosures of protected health information not covered by this Notice or the laws that apply to us will be made only with your written authorization.

PATIENT RIGHTS

Right to Access. You have the right to request to inspect and/or get copies of your protected health information for as long as we maintain it as required by law. You must submit your request in writing to our Medical Records Department. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, staff time or other supplies associated with your request. We may deny your request to inspect and copy in certain circumstances. If you are denied access to protected health information, you may request that the denial be reviewed. Another licensed health care professional chosen by Pavillon 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 an Electronic Copy of Electronic Medical Records. If your protected health information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity.

Notification of a Breach. You have the right to be notified in the event that we (or one of our Business Associates) discovers a breach of any of your unsecured protected health information.

Right to Amend. You have the right to request that we amend your protected health information if you feel the information is incorrect or incomplete. To request an amendment, your request must be made in writing explaining why the information should be amended and submitted to our Privacy Officer. We may deny your request under certain circumstances.

Right to Request Restrictions. You have the right to request that we place additional restrictions on our use or disclosure of your protected health information. We are not required to agree to any restriction that you may request. If we do agree to the restriction, we will comply with the restriction unless the information is needed to provide emergency treatment to you or unless the use or disclosure is otherwise permitted by law.

Right to an Accounting of Disclosures. You have the right to receive a list of instances in which we disclosed your protected health information during the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Out-of-Pocket Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to request in writing that your protected health information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about your protected health information by alternative means or alternative locations. Your request must be made in writing and must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.

Right to Paper Copy of Statement. You may obtain the Statement from our Privacy Officer.

COMPLAINTS AND QUESTIONS

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made regarding your health information, you may express your written complaint to us or the U.S. Department of Health & Human Services at the address below.

Our Privacy Officer If you want more information about our privacy policy or have questions or concerns, please contact us. Our Privacy Officer can be contacted at:

Pavillon
Privacy Officer
241 Pavillon Place
Mill Spring, NC 28756
(828) 694-2300

U.S. Department of Health & Human Services If you would like to submit a complaint directly to the U.S. Department of Health & Human Services please send it to the following address:

U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(877) 696-6775

We support your right to privacy of your protected health information. You will not be retaliated against in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.